



**MASS CASUALTY  
COMMISSION**  

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**COMMISSION  
DES PERTES MASSIVES**

**Environmental Scan of Prior  
Recommendations**

**Prepared by: Research & Policy Team  
August 2022**

# Environmental Scan of Prior Recommendations

PRIVILEGED & CONFIDENTIAL

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## 1. INTRODUCTION

This document brings together recommendations from previous reviews in Canada relating to the matters identified in the mandate of the Mass Casualty Commission. The scope of this scan includes reports of commissions of inquiry, reports of government standing committees, law reform commissions, government-commissioned evaluations and reviews, reports of the Civilian Review and Complaints Commission for the RCMP, and coroner's inquiries. Reports from public interest groups or think tanks are not included here, nor are reviews which do not contain recommendations.

The reviews are grouped according to the research structure developed by the Research & Policy team of the Mass Casualty Commission. Within each group, the reviews are listed in chronological order. Until the Commission completes its fact-finding process, the relevance of the recommendations has been determined on the basis of Foundational Documents and the Commission team's review of the information presently available to the Commission; the fact-finding process may yet contradict or refine this present understanding. Some recommendations have been included because although they do not address an issue directly relevant to the Commission's mandate, they address an analogous issue.

For each review, there is a brief summary of the background and mandate of the review, along with a list of the issues on which recommendations were made. The recommendations that are relevant to the Commission's mandate are set out. Edits to the original text of the recommendations have been made in a few cases, where necessary for clarity and conciseness. In some instances, information on the implementation of recommendations is included.

Each review is summarized once. However, many reviews relate to more than one matter within the Commission's mandate.

All citations are to the page of the report being summarized, except where otherwise indicated.

## 2. POLICE OVERSIGHT, TRAINING, PREPARATION, CULTURE

### 2.1. Nova Scotia

The Order in Council directs the Mass Casualty Commission to examine “the responses of police, including the Royal Canadian Mounted Police (RCMP) and municipal police forces” ((a)(ii)) and “police operations, including operational tactics, response, decision-making and supervision” ((b)(iv)). This section focuses on reviews involving policing in Nova Scotia. Reference should also be made to the reports described in section 6 of this scan relating to gender-based and intimate partner violence policies in Nova Scotia.

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#### 2.1.1. Royal Commission on the Donald Marshall Jr. Prosecution (1989)<sup>1</sup>

In 1971, Donald Marshall Jr., a 17-year-old Mi'kmaw<sup>2</sup> youth, and Sandy Seale, a 17-year-old Black youth, were walking through a park in Sydney, Nova Scotia when they met two men, Roy Ebsary and Jimmy MacNeil. Mr. Ebsary stabbed Mr. Seale and cut Mr. Marshall's arm. Seale later died. Mr. Ebsary had a reputation for violence and had a conviction on a weapons charge involving a knife. The Commissioners described the police conduct during the investigation as “entirely inadequate, incompetent and unprofessional.”<sup>3</sup> Due to their racist views of Indigenous people and opinions that Mr. Marshall was a troublemaker, police quickly decided, without evidence, that Mr. Marshall had stabbed Mr. Seale in the course of an argument. The investigators pressured teen witnesses into incriminating Mr. Marshall. The Crown prosecutor failed to disclose the witnesses' prior inconsistent statements. Mr. Marshall's defence lawyer failed to provide adequate representation, and the trial judge made legal errors (which were not raised before the Court of Appeal or identified by that court).

Ten days after Mr. Marshall was convicted of murder, Mr. MacNeil told police he had seen Mr. Ebsary stab Seale. The RCMP investigated Mr. MacNeil's statement at the request of the Sydney police and Attorney General, but their investigation was “incompetent and incomplete.”<sup>4</sup> The RCMP dismissed Mr. MacNeil's statement without interviewing him. His statement was not disclosed to Mr. Marshall's lawyer or to the Crown counsel handling his appeal, nor was a later report from Mr. Ebsary's daughter that she had seen him washing blood from his knife on the night of the murder. The wrongful conviction began to come to official attention only in 1981, after Mr. Marshall learned that Mr. Ebsary had admitted to killing Mr. Seale. The RCMP officers assigned to reinvestigate the case determined that Mr. Seale had been killed by Mr. Ebsary's knife. However, they pressured Mr. Marshall into saying, wrongly, that he and Mr. Seale had been attempting to rob Mr. Ebsary when the stabbing took place.

The federal Justice Minister referred the case to the Nova Scotia Court of Appeal and Mr. Marshall was released on bail in 1982, after spending 11 years in prison. The following year, the Nova Scotia Court of Appeal quashed Mr. Marshall's conviction and entered a verdict of acquittal. However, the Court of Appeal blamed Mr. Marshall for the conviction, stating that the murder took place in the course of an attempted robbery by Mr. Marshall, that Mr. Marshall had lied about the

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<sup>1</sup> Both the seven-volume report of the Royal Commission and the Digest of Findings and Recommendations are available at <https://archives.novascotia.ca/marshall/report/>.

<sup>2</sup> Micmac is the spelling offered in the Marshall Report. The correct singular reference is Mi'kmaw.

<sup>3</sup> “Digest of Findings and Recommendations,” pp. 2–3.

<sup>4</sup> “Digest of Findings and Recommendations,” p. 4.

robbery, and that his untruthfulness contributed to his conviction. Mr. Ebsary was eventually convicted of manslaughter.

The Royal Commission was appointed in 1986 and held 93 days of hearings. It concluded that “the criminal justice system failed Donald Mr. Marshall, Jr. at virtually every turn from his arrest and conviction in 1971 up to—and even beyond—his acquittal by the Supreme Court of Nova Scotia (Appeal Division) in 1983.”<sup>5</sup> The Commission found that the Court of Appeal made a “serious and fundamental error,” unsupported by any available evidence, when it concluded that Mr. Marshall was to blame for his conviction.<sup>6</sup>

The Commission also found that racism played a significant role in Mr. Marshall’s conviction, and made numerous recommendations to address anti-Indigenous and anti-Black racism in Nova Scotia’s criminal justice system and broader society. In order to determine how Mr. Marshall’s treatment differed from the treatment of other suspects, the Commission looked into RCMP investigations of two members of the Nova Scotia government and identified significant political interference in those investigations. This led the Commission to recommend the creation of the office of Director of Public Prosecutions, limiting the Attorney General’s ability to intervene in a prosecution.

The Commission made numerous findings regarding the conduct of the police during the investigation of Mr. Seale’s death and in the years following Mr. Marshall’s conviction. It concluded that in addition to racism, the investigation was affected by inadequate training and structural deficiencies. It found that many of the inadequacies of the initial investigation could be attributed at least in part to poor training and promotions that were based on seniority and “informal considerations” rather than merit.<sup>7</sup> It also noted that the RCMP re-investigation was in part responsible for bringing Mr. Marshall’s wrongful conviction to light.

The Commissioners noted the profoundly important role played by police agencies in Nova Scotia:

In a democratic, multicultural society committed to individual rights and civil liberties, and organized on the premise of equality of opportunity, the police have a profound and taxing responsibility to balance individual rights with society’s need for security.

Nova Scotians expect much of their police forces. Recent research, as well as work done for other Royal Commissions, indicates the public wants its police forces to exercise a wide mandate, to respond—and quickly—to calls for service, to solve crimes and be tough on criminals. At the same time—and equally important—Nova Scotians expect these functions to be carried out in an ethical way, with respect for the rights of the innocent, the accused and the victims. The police must be sensitive to racial, social and ethnic diversity, even-handed, principled and competent. If they fail to meet any of those expectations, of course, the criminal justice system may be brought into disrepute among the people it serves.<sup>8</sup>

The Report set out the significant improvements to policing that had been made in the 18 years between Mr. Marshall’s conviction and the Report’s publication in 1989, including recruitment, training, promotion, management, and oversight. However, it found that some deficiencies continued. For example, little training was provided to officers upon promotion. Further, the Commission concluded that training budgets continued to be inadequate and “in-service training

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<sup>5</sup> “Report of the Royal Commission,” Volume 1, Part 1, p. 15.

<sup>6</sup> “Report of the Royal Commission,” Volume 1, Part 1, p. 118.

<sup>7</sup> “Report of the Royal Commission,” Volume 1, Part 2, p. 263.

<sup>8</sup> “Report of the Royal Commission,” Volume 1, Part 2, pp. 249–50.

and regular programs of upgrading and certification are still woefully undeveloped.”<sup>9</sup> The Commission noted that despite significant improvements in investigation training for municipal police, more needed to be done to ensure a more uniform quality of investigative work across the province. This was particularly true in cases involving “juveniles and other persons deserving particular assistance.”<sup>10</sup>

The Commission expressed serious concern over the failure of other police officers or managers to question improprieties in the investigation. It noted that periodic review of investigations was standard practice in RCMP investigations and recommended it be implemented in municipal investigations. It also noted the need for improvements in the delivery of police services, despite limited resources:

Given the rising costs of police services, the growing demand for a wider range of quality police services and the stagnant tax base in many Nova Scotian municipalities, municipal police departments and their governing authorities must work to develop modes of cooperation to overcome their limited resources. We believe that the Province, through the Department of the Solicitor General, must carry through on announced intentions to examine the delivery of police services in Nova Scotia.<sup>11</sup>

It suggested that the province consider regionalizing policing to obtain a more effective and efficient policing service. Noting that several smaller municipalities had recently made decisions on whether to contract RCMP services or continue with local independent forces, mainly on the basis of cost, the Commissioners stated:

This is understandable, but affordability cannot be the only criterion in determining the kind of police force a municipality should have. We believe the Province has an obligation not only to establish minimum standards for policing, but also to provide municipalities with the resources to meet the implied financial obligations that go with such standards.<sup>12</sup>

The Commissioners also noted that the focus of municipal forces on responding quickly to local concerns can sideline the development of long-term plans and evaluating and auditing their performance. Municipal police departments should engage in more deliberative planning and monitor the successes and failures of those plans following implementation.<sup>13</sup>

It also outlined the differences in responsibility for the RCMP versus municipal forces, noting:

The RCMP is officially responsible to the Provincial Government under the Police Act and the Provincial Policing Agreement. In the municipal policing agreement the RCMP retains a significant degree of control, while at the same time the Police Act entrusts the municipality with the responsibility for the maintenance of law and order. Leaving aside the difficulties that could arise in a discussion of the legal status of policing agreements made under the Police Act, it is apparent that on a day-to-day basis, the RCMP has traditionally operated relatively autonomously in its relations with governing authorities in Nova Scotia.<sup>14</sup>

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<sup>9</sup> “Report of the Royal Commission,” Volume 1, Part 2, p. 264.

<sup>10</sup> “Report of the Royal Commission,” Volume 1, Part 2, pp. 266–67.

<sup>11</sup> “Report of the Royal Commission,” Volume 1, Part 2, p. 268

<sup>12</sup> “Report of the Royal Commission,” Volume 1, Part 2, p. 269.

<sup>13</sup> “Report of the Royal Commission,” Volume 1, Part 2, p. 270.

<sup>14</sup> “Report of the Royal Commission,” Volume 1, Part 2, p. 252.

The Commissioners considered options for changing the structure of policing to provide more centralized control over policing. They concluded that there was no need for any radical change to the structure of policing in Nova Scotia (such as centralizing control over police forces). However, they concluded that more should be done to provide leadership and direction on policing policy, particularly through the Police Commission. The Report went on to address the governance of RCMP detachments in the province:

One special concern in the overall municipal and provincial policing partnership concerns the relationship of both levels of government to RCMP policing in the province. Lack of accountability of the RCMP to provincial and municipal authorities has led elsewhere to calls for a provincial police force. Both municipal authorities and the Province must become more forceful about defining the relationship. At our peer review workshop to discuss the police research (see Volume 2, Appendix I), RCMP officials from Ottawa invited such input: "Let the Province develop a plan and we'll respond." The Province should take up that challenge.<sup>15</sup>

The Commissioners also considered the role of the Police Review Board, which was created to determine public complaints about police officers and review issues relating to the discipline of police officers. The Commissioners said:

The 1985 amendments to the Police Act created a new Police Review Board to hear and determine public complaints and review matters of internal discipline against police officers. These amendments largely followed the recommendations of Judge Nathan Green in his 1981 report on the Police Act. Whether or not this new Board will be effective will depend on the ability of its members to be and be seen to be independent of both Government and the police community. This independence should be fostered by a clear separation between the Board and the Nova Scotia Police Commission. We understand that the Chairman of the Police Commission is to be the Registrar of the Board, the investigative branch of the Commission will conduct investigations for the Board, and the budget of the Board will be part of that Commission. While we have commented earlier on the desirability of the independence of the Commission itself, we believe that linking the Police Review Board to the Police Commission in the manner proposed will lessen the confidence of the public and the police in the Board. When dealing with individual complaints and the rights of individual police officers, it is essential that the adjudicative body not be perceived as being aligned with one side or the other. Even though the Police Commission may itself be independent, it is inevitable that it will be viewed as being management or police oriented, and hence neither a private complainant nor a disciplined officer may feel that he or she has been treated impartially. We believe that in its essential aspects the Police Review Board should be separate from and independent of the Nova Scotia Police Commission.<sup>16</sup>

The Commission also warned against the potential for personal interference by elected politicians in the governance of the police, noting the dominance of elected politicians on municipal bodies governing police.<sup>17</sup>

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<sup>15</sup> "Report of the Royal Commission," Volume 1, Part 2, p. 256.

<sup>16</sup> "Report of the Royal Commission," Volume 1, Part 2, p. 258.

<sup>17</sup> "Report of the Royal Commission," Volume 1, Part 2, p. 259.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

- (Recommendation 15) We recommend that training for all police officers, both at the intake level and as continuing education, include content on police/minority concerns and sensitivity to visible minority issues.
- (Recommendation 28) We recommend that the RCMP and municipal police forces, where applicable, take immediate steps to recruit and hire Native constables.
- (Recommendation 47) We recommend that the Police Commission conduct regular assessments of the operations of each municipal police department in accordance with the provisions of the Police Act.
- (Recommendation 48) We recommend that the Solicitor General require the RCMP to provide information concerning RCMP operations in the province to the Police Commission on an ongoing basis so the Commission can develop and plan rational policing policy and an adequate police information system in the province.
- (Recommendation 49) We recommend that the Police Commission develop and maintain close liaison with officials in the Department of Municipal Affairs and the Executive of the Union of Nova Scotia Municipalities with a view to developing a more rational basis for provincial financial assistance for municipal policing services.
- (Recommendation 50) We recommend that the Police Commission not be absorbed into the mainline structure of the Solicitor General's Department to keep it relatively independent of political considerations and to better reflect the municipal-provincial partnership that characterizes the Nova Scotia organization of policing services.
- (Recommendation 51) We recommend the establishment within the Solicitor General's Department of an Executive Director (Policing) to reflect its increasing role in policing in the province.
- (Recommendation 52) We recommend that a regular annual meeting be held by the Police Commission with the chairs of all Nova Scotia boards of police commissioners. The purpose would be to provide a forum for information exchange, program development, and possible collaboration among municipal police departments in various matters from equipment to crime prevention.
- (Recommendation 53) We recommend that the Chairman of the Nova Scotia Police Commission not act as the Registrar of the Police Review Board and that the Nova Scotia Police Commission not provide investigative services to the Police Review Board.
- (Recommendation 58) We recommend that the Nova Scotia Police Commission take a strong leadership role in police/visible minority relations by providing useful materials to departments (comparable in quality to those now made available to its officers by the RCMP), arranging imaginative in-service training in conjunction with the Atlantic Police Academy or similar bodies, and assisting departments in the setting up of race relations liaison officers or committees.
- (Recommendation 59) We recommend that, together with the Nova Scotia Police Commission, municipal police departments and local boards of police commissioners develop imaginative outreach programs and liaison roles in order to provide visible minorities with greater access to and more positive interaction with the police.
- (Recommendation 60) We recommend that municipal police departments adopt as an objective the eradication in police departments of racial slurs and stereotyping and, in pursuit

of this objective, promulgate official policies and guidelines on stereotyping similar to those currently employed by the RCMP (RCMP Administration Manual 111.9) or the Metropolitan Toronto Police Force (standing order number 24).

- (Recommendation 61) We recommend that special attention be given to more intensive training for cadets whose first assignment will be in areas of high visible minority concentration. In addition, detachments and municipal police departments located in areas of high visible minority concentration should allocate proportionally more of their resources to multicultural and race relations training. The Police Commission should monitor detachment and municipal police department performance in this area.
- (Recommendation 62) We recommend that education and sensitivity training with respect to visible minorities be more pronounced in the cadet training curriculum and should be a component of regular in-service training.
- (Recommendation 63) We recommend that the Atlantic Police Academy be encouraged to continue to develop in-service programs and imaginative experimental initiatives for police/visible minority interaction.
- (Recommendation 68) We recommend that the Solicitor General's Task Force on Municipal Police Training, as well as the data collected as part of the Police Study for this Report, be used to establish an ongoing system for monitoring levels of training in the province. The system should be maintained by the Police Commission or equivalent body and should incorporate clear definitions of the types of training appropriate for the needs of particular members, departments and detachments.
- (Recommendation 69) We recommend that periodic assessment of municipal police department officers be carried out as in Nova Scotia's recently announced "force continuum program," which deals with the use of firearms and mace. Common standards should be developed for certification in these areas and consideration should be given to the inclusion of physical fitness and basic response/preliminary investigation imperatives.
- (Recommendation 70) We recommend that all constables be required to have basic investigative skills such as would be required to secure the crime scene and carry out proper preliminary recording and investigation.
- (Recommendation 71) We recommend that municipal police departments cooperate with the Police Commission to produce a uniform set of guidelines for investigative work.
- (Recommendation 72) We recommend that the Police Commission undertake a systematic evaluation of the investigative capacities available in all municipal police departments in the province. This evaluation should be coordinated with periodic reviews of the municipal police departments.
- (Recommendation 76) We recommend that it be standard practice in all police departments for superiors to review, with investigators, the progress of investigations of all serious offences.
- (Recommendation 77) We recommend that a joint task force be established by the Solicitor General and the Minister of Municipal Affairs, with representation from the other relevant bodies, to examine the organization and delivery of policing services within the province and in particular to consider and review the desirability and feasibility of some regionalization of existing municipal policing services in the province and to make recommendations to the Government on these matters. Such a review should also examine other less comprehensive collaborative arrangements which might beneficially be established or further developed

between existing municipal police forces and the RCMP to improve the quality and efficacy of the delivery of policing services in the province.

- (Recommendation 78) We recommend that all municipal police departments be able to deliver police services according to a set of minimum standards for policing in Nova Scotia. This set of standards should be developed by the Police Commission with appropriate input from both provincial (Solicitor General) and municipal (local police commissions) governing authorities. Recognizing that the primary responsibility for delivery of police services is with the municipalities and that it may be beyond the financial capability of some to upgrade their municipal police department according to these minimum standards, the Province must ensure that the municipal police departments have the resources to meet the prescribed standards.
- (Recommendation 81) We recommend that municipal police departments be encouraged to develop a code of ethics as positive guidelines for behavior. For purposes of continuity and consistency and for minimum standardization, such codes should be developed in consultation with the Atlantic Police Academy and the Police Commission.

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### **2.1.2. Inquiry into Matters Relating to the Death of James Baily, Jr. (Nova Scotia Police Commission, 2005)<sup>18</sup>**

James Bailey was a Cape Breton man who was known by his family to have substance use problems and to have experienced suicidal ideation. In May of 2000, he asked family members for assistance to get to a detox centre. However, there were no available beds. A family member called police and reported that Mr. Bailey was intoxicated and wanted to be picked up. Shortly thereafter, Mr. Bailey was arrested on the street under the Liquor Control Act for public intoxication and placed in custody. The officer who arrested him found a bottle of pills in Mr. Bailey's pocket. Mr. Bailey was placed in the recovery position on the cell bunk. The custodian in the police station did not physically check on him for more than two hours; she relied on the video monitor. Mr. Bailey died in his cell at some point during this period. The autopsy showed several narcotics and controlled pharmaceuticals in his system, two of which were at toxic levels.

The Nova Scotia Police Commission conducted a Commission of Inquiry in response to a complaint by Mr. Bailey's family. The Commission identified the limited budget of the Cape Breton Regional Police Service (CBRPS) as contributing to the lack of training around matters such as drug recognition and the effects of mixing drugs and alcohol. It also identified that training regarding proper procedures for monitoring people in cells was poor. The Commission identified several weaknesses in the Prescription Monitoring Association of Nova Scotia (PMANS), which oversees prescription processes of physicians with the goal of reducing the over-prescribing and trafficking of prescribed medications. The RCMP participates in this program, but local police do not, and the system requires manual entry of information, resulting in significant delays.

The Commission also noted there was no formal approach for Nova Scotia police to learn and disseminate information from other jurisdictions and agencies, such as alerts regarding the dangers inherent in mistaking intoxication by drugs for alcohol abuse.

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<sup>18</sup> "Report of the Commission of Inquiry into Matters Relating to the Death of James Guy Bailey, Jr." Nova Scotia Police Commission (September 2005), <https://novascotia.ca/just/publications/docs/JamesGuyBaileyInquiry09-1-05.pdf>.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

- (Recommendation A-1) The CBRPS must find the ways and means of providing adequate continuing education to its officers and employees. [...]
- (Recommendation A-2) Police forces should develop a means of “flagging” their computer databases in regard to known substance abusers and persons with a history of suicide attempts or mental illness. This information would only be gathered from police records and recorded officer experiences in order to comply with privacy requirements.
- (Recommendation B-7) The Operational Policy on the Care and Handling of Prisoners should be amended to direct the arresting officer to check for CPIC and in-house records to assist in determining if the prisoner has an arrest history, a history of mental illness, suicidal tendencies, a history of drug use, or other information relevant to the prisoner’s well-being while in the lockup.
- Recommendation B-19) The possibility and means of receiving and disseminating information received from other jurisdictions should be explored. The possibility of this information transfer in conjunction with the Nova Scotia Police Commission should be explored.
- (Recommendation I-5) The CBRPS must insure that all officers are briefed on current and new policies and procedures. Duty sergeants, or other appropriate supervising officer, must be made responsible for ensuring that all policies and procedures are reviewed by each officer. This must be more than just handing the policy and procedure manuals to officers and requesting a signature. Performance reviews may be the most opportune time for ensuring familiarity with the policy and procedures among the officers.
- (Recommendation J-1) The PMANS needs to be brought into the 21st century and computerized. A network should be created that would allow physicians, pharmacists and emergency departments to access the database. Because this requires an allocation of human resources and financing, the how and the when should be left to the provincial government and other interested parties. However, this matter is reaching crisis proportions and must be considered a priority.
- (Recommendation J-2) The annual budget for the PMANS must be increased to a level that is realistic in light of the scale of the current problem. Budgeting for the maintenance of the computer network system mentioned above should be included in this increase.

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#### **2.1.3. Inquiry into Matters Relating to the Death of Dean Richard (Nova Scotia Police Commission, 2005)<sup>19</sup>**

This inquiry by the Police Commission<sup>20</sup> was ordered by the Minister of Justice following complaints by the parents of a young man killed in a car accident in 1996. The man, Dean Richard, had been thrown from a car and was on the ground when a police officer on patrol came upon the scene. The officer stopped his car and did not block the highway or switch his emergency lights on immediately. Another car driving along the highway passed the officer and hit Mr. Richard, who later died from his injuries. The family raised concerns about the quality of the

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<sup>19</sup> “Report of the Commission of Inquiry into Matters Relating to the Death of Dean Richard.” Nova Scotia Police Commission (July 2005).

<sup>20</sup> The Nova Scotia Police Commission was the precursor organization to the present Office of the Police Complaints Commissioner of Nova Scotia.

investigation, the officer's failure to block the highway or switch his emergency lights on to alert oncoming traffic to the accident, and the quality of communication between the police and the family and between the Department of Police and Public Safety Services after the accident.

The Commissioner did not make any findings adverse to the police. He made recommendations regarding emergency lights in police cars, police communication with families, and the timelines governing complaints to the Police Commission.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 2) Each police department would consider assigning one contact person to deal with family when serious questions or concerns arise. This person should be trained in conflict management and have access to all pertinent information.
2. (Recommendation 3) Appropriate procedures and protocols be developed by Police and Public Safety Services to assist with their approach to members of the public in a consistent, timely manner.
3. (Recommendation 4) The person with Police and Public Safety Services assigned as the public contact person have training in conflict resolution and mediation.

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#### **2.1.4. Victoria Rose Paul Investigation (Nova Scotia Police Complaints Commission, 2012)<sup>21</sup>**

In August 2009, Victoria Paul, a Mi'kmaw woman, died of a stroke in Truro while in detention following her arrest for public intoxication. The stroke was not caused by trauma or intoxication. She was alert and able to communicate and walk when she arrived but showed clear signs of deterioration for several hours before she was medically assessed. Staff assumed she was still intoxicated, even ten hours after her arrest. They left her lying in her own urine for several hours.

The Chief of the Truro Police Service asked the Halifax Regional Police to conduct an operational review of the matter, which appeared to focus only on whether police conduct caused Ms. Paul's stroke. (This review took place before the Serious Incident Review Team became operational in Nova Scotia.) In 2011, Nova Scotia's Minister of Justice ordered the Police Complaints Commission to review Ms. Rose's detention and death, as well as the adequacy of the HRP's investigation. This review made the following findings:

1. Members of the Truro Police Force failed to appropriately monitor Ms. Paul's health and provide her with timely access to medical assistance and failed to treat her with respect and dignity.
2. Truro police had significant training in a number of relevant areas yet demonstrated complacency toward the care and custody of apparently intoxicated people.
3. The Halifax Regional Police investigation was very narrow in focus. Because the Chief of the Truro Police Service was related to the Deputy Chief in Halifax, Ms. Paul's community believed the HPS was not impartial.

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<sup>21</sup> "Victoria Rose Paul Investigation Report." Nova Scotia Police Complaints Commission (May 2012), [https://novascotia.ca/just/global\\_docs/Victoria\\_Rose\\_Paul\\_Investigation\\_Report\\_20120524.pdf](https://novascotia.ca/just/global_docs/Victoria_Rose_Paul_Investigation_Report_20120524.pdf).

4. Provincial standards for lock-up facilities needed clarification and updating. The review noted that few of the recommendations from the Bailey inquiry (above), which raised very similar issues in 2005, had been implemented. However, a new provincial committee had been set up to revisit the provincial policing standards.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

- (Recommendation 3) Truro Police Service to provide officers and custodians adequate on-site training in order for these employees to sufficiently carry out their duties. This training should include at a minimum proper training on the policies and provincial standards of the care and custody of prisoners, how to interact with challenging or intoxicated individuals, conflict resolution, suicide intervention, use of force, how to conduct quality checks on persons in custody, and how to determine whether medical assistance is required.
- (Recommendation 7) Truro Police Service provide all officers, civilian staff, and custodians sensitivity and cultural awareness training.

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#### **2.1.5. Inquiry into the Death of Howard Hyde (Nova Scotia Provincial Court, 2010)<sup>22</sup>**

Judge Anne Derrick of the Nova Scotia Provincial Court conducted this review of the death of a man with severe schizophrenia while in custody of the Halifax Regional Police Service. Mr. Hyde had been arrested after assaulting his common-law partner. He had been experiencing a recurrence of his schizophrenia, which caused paranoia, anxiety, agitation, and psychosis. Mr. Hyde's partner told the officers who arrested him that he was "schizophrenic" and had told 911 that he would respond violently to any intervention, had mental health issues, had not been taking his medication, and that he had been tasered in the past and was paranoid of police. Mr. Hyde was passive and cooperative during the arrest. Judge Derrick found that the arresting officers were professional and responsible but did not appreciate that Mr. Hyde was experiencing a serious mental health crisis and did not believe they had grounds to apprehend him under Nova Scotia's Involuntary Psychiatric Treatment Act. Judge Derrick concluded that the information his partner had given to 911 did in fact give grounds to do so. However, it was unclear whether that information was communicated to the arresting officers. The officers did not ask the Mobile Mental Health Crisis Team to attend.

After Mr. Hyde spent an hour in a holding cell, his arresting officer and two officers responsible for booking prisoners attempted to cut the laces in Mr. Hyde's shorts. Mr. Hyde had been unable to untie them. Mr. Hyde became terrified of the cutting device and struggled with the officers in an attempt to escape. The officers did not have training on dealing with people with mental illness and had not been told of Mr. Hyde's illness. They did not call the Mobile Mental Health Crisis Team. After trying to restrain Mr. Hyde, they used a Conducted Energy Weapon (Taser) on him repeatedly.

Once the booking officers wrestled him to the floor, Mr. Hyde lost consciousness and stopped breathing. He was revived and taken to hospital. Seven hours later, he had stabilized and was discharged back into police custody. The ER physicians were of the view that he urgently needed a psychiatric assessment and treatment; however, they erroneously believed the court would

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<sup>22</sup> "In the Matter of a Fatality Inquiry Regarding the Death of Howard Hyde: Report Pursuant to the *Fatality Investigations Act*." Nova Scotia Provincial Court (November 2010), [https://www.courts.ns.ca/provincial\\_court/NSPC\\_documents/NSPC\\_Hyde\\_Inquiry\\_Report.pdf](https://www.courts.ns.ca/provincial_court/NSPC_documents/NSPC_Hyde_Inquiry_Report.pdf).

send him for a clinical psychiatric assessment (rather than a forensic psychiatric assessment) and he would then obtain the care he required. The officers who transported him from the hospital to court did not make any entries in the police database that he had received an injection of schizophrenia medication, that he needed to be seen by a mental health professional, or that he could alternate between being lucid and incoherent. Mr. Hyde appeared in court but was remanded to the Central Nova Scotia Correctional Facility overnight as it was too late in the day to arrange bail and his release. He paced all night and did not sleep. The next morning, when leaving his cell to go to court, he became fearful and tried to escape. He struggled with the correctional officers. These officers did not know of his mental health history or of his behaviour overnight and had no training in mental health issues or crisis intervention techniques. He was taken to a cell and again struggled with the officers vigorously while prone on the floor of the cell for two and a half minutes. He stopped breathing, with no pulse. He was transported to hospital and pronounced dead.

Judge Derrick concluded that the officers who were involved in Mr. Hyde's arrest would have benefitted from training in dealing with people with mental illness, in the role and function of the Mobile Mental Health Crisis Team, and in their powers under the Involuntary Psychiatric Treatment Act, as well as clearer policy guidance on what can trigger those powers.

With respect to the officers' use of a Taser during the incident in the booking area, Judge Derrick found that although the Taser was done according to policy, it was ill-advised and only aggravated the situation.

Judge Derrick concluded that the officers' use of force on the morning of Mr. Hyde's death was reasonable and proportionate. She also concluded that he died as the result of physiological changes in his body brought on by the intense struggle with the officers, and that this was accidental.

Judge Derrick concluded that the officers who interacted with Mr. Hyde would have benefitted from training in dealing with people with mental illness, the MMHCT, and crisis intervention techniques. She noted that since his death, significant changes had been made to training, legislation, and policies to ensure that frontline responders in Nova Scotia are able to respond appropriately to people with mental illnesses.

Judge Derrick also noted that although Mr. Hyde was living in Halifax at the time of his arrest, he had previously lived in rural Nova Scotia and had to rely on in-hospital treatment due to the absence of community mental health supports or services. She recommended that the province examine how mental health services for persons in conflict with the law could be enhanced outside of Halifax, and made numerous other recommendations to improve the mental health system in Nova Scotia.

In 2011, the Nova Scotia government released a plan for improving its response to people with mental illness in the criminal justice system.<sup>23</sup> It published an update on progress toward that plan in 2012.<sup>24</sup>

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<sup>23</sup>"Building Bridges: Improving Care in Custody for People Living with Mental Illness", available at [https://novascotia.ca/just/hyde\\_inquiry.asp](https://novascotia.ca/just/hyde_inquiry.asp)

<sup>24</sup> [https://novascotia.ca/just/global\\_docs/Hyde\\_Report\\_Response.pdf](https://novascotia.ca/just/global_docs/Hyde_Report_Response.pdf)

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

- a) The Province should develop a provincial mental health strategy that ensures coordination of care, integration of services and supports, and monitors quality and outcomes in relation to mental health generally and mental health in the context of the criminal justice system. The Strategy should be informed by “best practices” and the Convention on the Rights of Persons with Disabilities.
- b) The Province should create a position in government of Director of Mental Health Strategy whose mandate will be to oversee and be accountable for the Province’s mental health strategy. The position would also involve responsibility for monitoring the treatment of persons with mental illness by the various components of the justice system and oversight of mental health training for Department of Justice employees.
- c) The Director of Mental Health Strategy should have recent, relevant experience in mental health policy generally and mental health policy in the context of criminal justice.
- d) The Province should establish an inter-departmental (Justice and Health) Committee, to address mental health issues in the criminal justice system. The Committee should report to the Deputy Ministers for Health and Justice.
- e) The Director of Mental Health in Criminal Justice should chair the Justice and Health Committee. Membership on the Committee should not be limited to representatives from the Departments of Justice and Health and should include representation from the Capital District Health and a senior member of the Halifax Regional Police Service. The Department of Community Services should also be invited to participate. The Committee should also include a representative from each of the Schizophrenia Society of Nova Scotia and the Canadian Mental Health Association, to be selected by those organizations.
- f) The Director of Mental Health Strategy and the Justice and Health Committee should carefully review the content of the Consensus Project<sup>25</sup> to identify what might be valuable in improving the Nova Scotia criminal justice system’s response to persons with mental illness.
- g) Through a collaboration of departmental representatives, (Department of Health, Department of Justice), Capital District Health, health professionals, police representatives, mental health “consumer” representatives and other appropriate participants, issues relating to service modalities and service delivery, access to services and suitability of services and supports should be assessed.
- h) The Province through its funding of mental health services, should support community-based mental health programmes and services and alternative treatment modalities to pharmacological and involuntary hospitalization models.
- i) The Province should significantly increase funding for mental health services. This increase in funding should not be achieved through a reallocation of existing health care funding.
- j) Increased funding for mental health services should be directed to: enhancing support for improved community-based mental health services, increased training for front-line police officers, sheriffs and correctional officers, supports for family physicians providing mental health services to patients, increasing and improving community awareness about and understanding of mental illness, in the general public and particular groups such as police

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<sup>25</sup> This is a 2002 report of the Council of State Governments Justice Centre, an American non-profit organization focused on public safety. The Criminal Justice/Mental Health Consensus Project focused on improving the criminal justice system’s interactions with people with mental illness. <https://csjusticecenter.org/publications/the-consensus-project-report/>

officers, teachers, family physicians and members of the justice system, and campaigns to eliminate the stigmatization of persons living with mental illness.

- k) The proportion of the mental health budget directed to the provision of treatment and support in community settings should be increased.
- l) The Department of Health should explore alternate means of delivering mental health care and treatment in order to provide greater access to mental health services. Greater use could be made of nurse practitioners specializing in psychiatric issues, in community-based, mental health clinics. Individual psychiatrists could provide consultation services for family medicine practice groups.
- m) The Department of Health, Mental Health Services Branch should recognize the value of Peer Support and through appropriate policy development, working in conjunction with existing Peer Support programs being delivered by CMHA, Self Help Connection and Healthy Minds Cooperative, proceed with broader implementation of more fully funded Peer Support Programs with paid Peer Support Workers.
- n) The Province should examine how mental health services for persons in conflict with the law can be enhanced outside of the Halifax Regional Municipality.
- o) Halifax Regional Police and health authorities (CDHA and IWK) should continue and expand their collaborative work, including better and more comprehensive education in the law enforcement community regarding the mandate and ability of the Mental Health Mobile Crisis Team to provide advice and conduct mobile visits at any stage of the justice system process. This should include exploration of additional models for police and mental health collaboration when responding and providing service to persons with mental illness.
- p) The MMHCT [Mobile Mental Health Crisis Team] and its supporting agencies should promote greater awareness among emergency department physicians and nursing staff, family physicians, justice system officials, family members, friends, community-based organizations and other social supports of people with a mental illness about the Team's ability to provide advice, including about community supports and resources, and to conduct mobile visits and assessments at any stage of the person's illness.
- q) The Mobile Mental Health Crisis Team should ensure it has protocols in place that direct follow-up of a contact with the Team in all cases to ensure that the person who has been the subject of the call is receiving appropriate services. A detailed record should be made of a follow-up or a case debriefing.
- r) In recognition of the role police officers play as mental health first responders, the Province should fund a police access line so that information about mental health services available through the health care system and in the community is readily available to all patrol and Booking officers in particular. The inventory of services could be compiled through a collaboration of the Departments of Justice, Health, and Community Services and the Capital District Health Authority, the Mobile Mental Health Crisis Team, and the Schizophrenia Society and the Canadian Mental Health Association. The inventory of services should identify the nature of the service and appropriate contact information and be updated regularly so that the information being relied on by police officers coming into contact with persons with a mental illness is accurate and current.
- s) The [Justice and Health] Committee referred to in Recommendation #4 should monitor the work of the Mental Health Commission of Canada to identify "best practices" for developing a provincial anti-stigma campaign. The Province should support local community initiatives and

programmes that promote an anti-stigma, inclusive message or engage in a positive stigma-reduction activities.

- t) The Province, Health Authorities, policing services and members of the health care and justice communities should immediately adopt respectful language that is appropriate in identifying persons with a mental illness: persons with a mental illness, persons living with a mental illness.
- u) The Province should be addressing in the context of its proposed *Personal Health Information Act* (Bill 64) and the development of its electronic health record system – SHARe (Secure Health Access Record), the issues of confidentiality and privacy rights, consent, disclosure and stigma as they specifically relate to the health care records and needs of mental health service users and persons in custody, and consulting with the affected constituencies and mental health service providers.
- v) All persons in the justice system who have contact with persons with mental illness should receive training that includes: current information about community resources and supports for persons with mental illness; basic human rights principles; empathy; anti-stigma awareness; communication and listening skills.
- w) Training should assist in the identification and care of persons who may be experiencing a psychiatric emergency. This would include topics such as identification of mental health issues, determination of whether a medical referral is needed, and development of skills for communicating with persons with mental illness.
- x) All training of persons in the justice and health care systems with respect to mental health issues should involve or continue to involve persons with lived experience with mental illness, including, where relevant and feasible, lived experience with mental illness and the criminal justice system.
- y) The Halifax Regional Police should adopt the objective of providing Crisis Intervention Training to all patrol officers as well as all booking officers and all officers who provide use of force training in the Department.
- z) The Halifax Regional Police Service should continue training members to be part of the Mobile Mental Health Crisis Team.
- aa) The Halifax Regional Police should enhance the Canadian Police Knowledge Network online training “Recognizing Emotionally Disturbed Persons”, which is currently offered as a “baseline” training program, with skills development through role-playing and in-classroom instruction and trainer/learner interaction.
- bb) The Department of Justice should integrate Crisis Intervention concepts and skills-instruction into the joint, use of force training program being developed in the Department.
- cc) The Department of Justice should enhance the Canadian Police Knowledge Network online training “Recognizing Emotionally Disturbed Persons”, which is currently offered as a “baseline” training program in mental health issues, with skills development through role-playing and in-classroom instruction and trainer/learner interaction.
- dd) The Minister of Justice should undertake an annual review of the implementation of the Recommendations of this Inquiry, which review to be completed by the anniversary date of the filing of the Inquiry’s Report, and made public no later than two months from that date, including by posting the review on the Department of Justice website.
- ee) The implementation of these Recommendations should be informed by and consistent with the principles of the Convention on the Rights of Persons with Disabilities.

ff) The Province should post this Report on the Department of Justice website.

## 2.2. The Rest of Canada

This section summarizes reports focused on police culture outside of Nova Scotia. Reference should also be made to the reports summarized in Section 3, “Communications among and within Law Enforcement Agencies,” and Section 4, “Communications with Community.”

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### 2.2.1. Aboriginal Justice Inquiry of Manitoba (1991)<sup>26</sup>

This inquiry was established in 1988 following public concern about the response of the Manitoba justice system to the deaths of two Aboriginal people, Helen Betty Osborne and J.J. Harper.

Ms. Osborne was killed in 1971 in The Pas. Although the identities of the four men who were present when she was killed were widely known in the community, the case was not brought to trial until sixteen years after her death, in 1987. Every Indigenous member of the jury was eliminated through peremptory challenges, two of the four men were charged, and only one was convicted of any crime.

J.J. Harper, who was the executive director of the Island Lake Tribal Council, died in 1988 following an encounter with a City of Winnipeg police officer. The police department conducted an internal investigation within a day, exonerating the officer involved. Members of the public demanded public inquiries in the wake of these deaths and the justice system’s responses.

The Commissioners were Alvin Hamilton, former Associate Chief Justice of the Manitoba Court of Queen’s Bench, and Murray Sinclair, then-Associate Chief Justice of the Manitoba Provincial Court. The mandate of the inquiry was to examine the relationship between Aboriginal people and the justice system and suggest mechanisms for improvements. It also specifically examined the Osborne and Harper cases. The inquiry held over 120 days of hearings and visited 36 Aboriginal communities across Manitoba, where members of the communities described their experiences with and feelings about the justice system. The inquiry also conducted research, commissioned research papers, held a symposium with tribal courts, and convened a conference with Indigenous Elders. The Final Report was issued in the autumn of 1991 and included 296 recommendations.

The Report began with the following statement:

The justice system has failed Manitoba’s Aboriginal people on a massive scale. It has been insensitive and inaccessible and has arrested and imprisoned Aboriginal people in grossly disproportionate numbers. Aboriginal people who are arrested are more likely than non-Aboriginal people to be denied bail, spend more time in pre-trial detention and spend less time with their lawyers, and, if convicted, are more likely to be incarcerated.

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<sup>26</sup> “Report of the Aboriginal Justice Inquiry of Manitoba.” Public Inquiry into the Administration of Justice and Aboriginal People (1991), available on the website of the Aboriginal Justice Implementation Commission at <http://www.ajic.mb.ca/volume.html>.

It is not merely that the justice system has failed Aboriginal people; justice also has been denied to them. For more than a century the rights of Aboriginal people have been ignored and eroded. The result of this denial has been injustice of the most profound kind. Poverty and powerlessness have been the Canadian legacy to a people who once governed their own affairs in full self-sufficiency.<sup>27</sup>

### **The Death of Helen Betty Osborne**

Ms. Osborne, nineteen years old, was walking down a street in The Pas on the morning of November 13, 1971 when she was attacked by four men who forced her into their car and drove away. She was physically and sexually assaulted at two locations. She was viciously beaten and stabbed with a screwdriver, and then dragged into the bush. Her body was discovered the next morning. The police were sensitive when notifying Ms. Osborne's mother of her death and initially kept her apprised of the investigation, but the Commissioners noted that they did not offer her any counselling or support assistance. Police also failed to keep her informed as the years progressed.

In the immediate aftermath of Ms. Osborne's death, the RCMP questioned several of her friends, all of whom were Aboriginal. These interrogations were often brutal and insensitive. They brought one young woman they were questioning, Annaliese Dumas, out of town and threw her against the hood of a car when she became tongue-tied. They then took her to the morgue to show her Ms. Osborne's severely battered body, a traumatizing and unjustified action.<sup>28</sup> Police brought another Aboriginal youth, Cornelius Bighetty, in for questioning and showed him pictures of Ms. Osborne's body, causing him to faint. He was 17 years old, and his caregivers had not been informed of the interrogation, let alone asked permission for its conduct, as required by law.

Police made no progress until they received a letter six months later from an anonymous woman who had been told of the murder by one of the assailants. That letter identified three of the assailants, James Houghton, Lee Colgan, and Bernard Manger. An informant then identified Dwayne Johnston as the fourth assailant. The four men refused to speak to police, and the investigation stalled. In 1985, the RCMP put an ad in a local newspaper asking for public assistance to solve the murder. They then received reports that Mr. Colgan and Mr. Johnston had made several comments over the years about participating in the murder. Mr. Colgan and Mr. Johnston were both charged with first-degree murder in 1986. Mr. Colgan agreed to testify against Mr. Johnston in exchange for complete immunity.<sup>29</sup> On the basis of Mr. Colgan's evidence, Mr. Houghton was charged. Mr. Johnston was convicted of second-degree murder and sentenced to life imprisonment without eligibility for parole for ten years. Mr. Houghton was acquitted. No charges were ever laid against Mr. Colgan (due to the immunity agreement), or against Mr. Manger.

The Commissioners found that the RCMP detachments in The Pas made extensive and appropriate use of the resources and people that were made available to them. Over 50 officers in The Pas and around the country worked on the investigation in the first year alone. The Commissioners were critical of some aspects of the investigation, including poor-quality photography and improper treatment of footprints around Ms. Osborne's body. They also noted a

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<sup>27</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume I, chapter 1.

<sup>28</sup> The Commissioners also pointed out that this showed disrespect for Ms. Osborne's body, which could be attributed to racism on the part of the investigators. "Report of the Aboriginal Justice Inquiry of Manitoba," volume I, chapter 9.

<sup>29</sup> The Commissioners found this to be a reasonable decision, given the dearth of evidence against Mr. Colgan and the other accused.

significant error with respect to the search for the car that transported Ms. Osborne to the scene of her murder. A taxi driver had told the investigators that on the day of the murder, he had noticed a car on the highway near where Ms. Osborne's body was found, close to the likely time of the murder. He remembered four digits of the license plate number. The police issued a province-wide request of officers to check cars with similar plate numbers. Eventually, through diligent police work, the investigators discovered that the only car from The Pas with a license plate with the same four numbers was registered to Harold Colgan, the father of Lee Colgan. However, instead of seizing Mr. Colgan's car, they relied on a report from an officer from another detachment. This officer had reported that during a routine check around the time of the murder (and not in response to the province-wide request), he had looked in the back seat of the Colgan vehicle and seen nothing unusual. He said that he knew the person driving the car, Lee Colgan. There was no record of this check, and the officer who conducted the check did not appear to have known that a murder had occurred. The Commissioners stated:

It is difficult to understand why the rural detachment would refrain from what would be a normal follow-up on the excellent work they had done just because an officer from the town detachment seemed to "vouch for" the owner of the car. No effort was made to do what had been requested of other detachments—to determine the whereabouts of any vehicle with the numbers 5342 in the licence on the night of the murder. ...

It would be easy to conclude that the middle-class status of the Colgan family was a contributing factor to the RCMP's casual approach to checking their vehicle. Less "respectable" citizens surely could not expect such deferential treatment.<sup>30</sup>

Months later, after receiving the letter implicating Mr. Colgan, Mr. Houghton, and Mr. Manger, the RCMP did seize and search Mr. Colgan's car. They found a strand of hair, a blood stain that could not be identified, and a piece of a brassiere that matched a brassiere found by the side of the road. They did not find any fingerprints.

Police then learned from an informant of Mr. Johnston's involvement. They asked Mr. Colgan and Mr. Houghton's parents for permission to question them (which was not required, as both were over 18); permission was declined. The Commissioners concluded that although the police did not have grounds to lay a charge, they did have sufficient information at this time to arrest any or all of the four suspects and take them to the detachment for questioning. The Commissioners noted that the police took Aboriginal friends of Ms. Osborne's to the detachment for questioning and suggested the reluctance to question Mr. Houghton and Mr. Colgan "may have been prompted by the suspects' middle-class status."<sup>31</sup> The only member of the group of four suspects to be questioned in a manner similar to the Aboriginal friends of Ms. Osborne was Mr. Manger, whose mother was Aboriginal. A few months after receiving the anonymous letter implicating him, two officers took Mr. Manger out of town to the bush. They asked him what really happened. Mr. Manger feared they were going to beat him. He agreed to do a polygraph test, and the officers returned him to town. Before the polygraph could be administered two days later, Mr. Manger spoke to a lawyer, who withdrew Mr. Manger's consent to the polygraph and asked the police to stop harassing him.

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<sup>30</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume II, chapter 4.

<sup>31</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume II, chapter 4.

The Commissioners stated the following:

There is a striking contrast between the way the three non-Aboriginal suspects were dealt with and the manner in which the Aboriginal informants were treated. The parents of Houghton and Colgan were consulted before a formal interview was attempted. Their wishes that their sons not be interviewed were largely respected. Neither Colgan nor Houghton were taken into the bush to be questioned. But Manger and [Annaliese] Dumas both were, and both are Aboriginal. Dumas, it should be noted, is also a woman. While we have no sympathy for Manger, it is clear that the RCMP acted improperly towards him and Dumas. This apparent difference in treatment suggests that the RCMP tailored their treatment in accordance with the race, sex or class of the person with whom they were dealing.

This contrast lends further credence to the belief that Aboriginal people were not treated with the same respect as non-Aboriginal persons. In view of the deference shown to the Colgan family, the conclusion is inescapable that the inappropriate treatment of [Cornelius] Bighetty, Dumas and others occurred because they were Aboriginal and, therefore, in the eyes of these officers, less deserving of courtesy and respect.<sup>32</sup>

The Commissioners also commented on the failure of the higher levels of the RCMP at Divisional Headquarters to adequately supervise the members of the Pas detachment, who were less experienced.

The Commissioners also examined whether it was widespread knowledge in the community within a short time of Ms. Osborne's death that the four suspects were responsible. They concluded that some who were friends and family members of the perpetrators remained silent to protect them; others feared the perpetrators. There were also rumours in the broader community that the four men were responsible. The Commissioners noted that the silence of these community members suggested a poor relationship between the police and the community: "Either the police were not close enough to the community to hear the rumours, or the community members did not feel close enough to the police to discuss matters of this kind with them."<sup>33</sup> The Commissioners noted, however, that many people did come forward years later when the police requested public assistance with the investigation.

With respect to the general disinclination of people to report information about crime involving others, the Commissioners commented as follows:

Our society generally shows an indifference to the victims of crime. Unless there is a direct personal connection to victims, it is all too easy for us to disregard their plight. It is easier and safer not to become involved... Indifference to the victims of crime takes the form of detachment and passivity, a kind of personal insulation from the unpleasant realities of the world around.

Coupled with this is the attitude that crime is a matter for the police. This attitude serves to release individuals from taking personal responsibility even in situations where they have knowledge which might further the cause of justice. Many people in our society feel estranged from the police, making it all the more likely they will attempt to remain uninvolved.

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<sup>32</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume II, chapter 4.

<sup>33</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume II, chapter 5.

All these attitudes seem to have been at play in The Pas during the investigation of the murder of Betty Osborne. Indifference to the victim and a wish to remain uninvolved were probably more powerful motivating factors than was racism.<sup>34</sup>

The Commissioners also addressed the murder itself, concluding that it was a racist and sexist act, and that Ms. Osborne would still have been alive if she had not been an Aboriginal woman. They concluded that Ms. Osborne's attackers believed that Aboriginal women were "objects with no human value beyond sexual gratification."<sup>35</sup> They noted that cruising for sex was common in the community at the time and that young Aboriginal women were usually the targets, but the RCMP did not consider this worth patrolling. The Commissioners expressed outrage that women, particularly Aboriginal women, were treated this way:

Violence against women has been thought for too long to be a private affair. Assaults on women have not been treated with the seriousness which they deserve. Betty Osborne was one of the victims of this despicable attitude towards women.<sup>36</sup>

The Commissioners also noted that many participants in the inquiry suggested that Ms. Osborne's murder would have been investigated differently if she had been white.

The Commissioners also made findings and recommendations about the jury pool composition and use of peremptory challenges, which allowed defence counsel to reject all six Aboriginal people who were called as potential jury members at the murder trial.

### **The Death of John Joseph Harper**

John Joseph Harper was a member of the Wasagamack Indian Band and executive director of the Island Lake Tribal Council. He was 37 years old and had a wife and children. In the early hours of March 9, 1988, Mr. Harper was killed by a bullet from a service revolver belonging to Constable Robert Cross of the Winnipeg Police Department. The following day, the Firearms Board of Enquiry of the Winnipeg Police Department concluded that Mr. Harper had assaulted Constable Cross, that there had been a struggle for Constable Cross' revolver, and that the revolver had discharged accidentally. An inquiry under the Manitoba Fatality Inquiries Act also concluded that the shooting was accidental and that Constable Cross' attempt to keep control of his gun was justified.

The Commissioners of the Aboriginal Justice Inquiry produced extensive findings about Mr. Harper's death and the resulting investigations. On the evening of March 8, 1988, Mr. Harper was socializing in the lounge of the Westbrook Hotel in Winnipeg. Test results at the time of death showed that he had high blood alcohol levels. He left the hotel to walk home at approximately 2:00 AM. Earlier that evening, a young Aboriginal man named Melvin Pruden had stolen a car from the Westbrook Hotel parking lot and gone joy riding with a friend, whose name is not stated in the Report. The car was reported stolen. At approximately 2:00 AM, at the same time that Mr. Harper was leaving the hotel, two Winnipeg Police Officers, Constable Cross and Constable Hodgins, were patrolling near the hotel. They saw the stolen car and began to chase it. Mr. Pruden and his friend abandoned the car and fled on foot. The officers followed them until they disappeared.

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<sup>34</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume II, chapter 5.

<sup>35</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume II, chapter 5.

<sup>36</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume II, chapter 5.

Constable Cross caught up with the young friend, and he and Constable Hodgins questioned him in the police car. Constable Hodgins told the Commissioners that she made notes of what the youth said on a scratch pad rather than in her notebook and subsequently lost the scratch pad notes. Constable Hodgins radioed that the other suspect was “Male, native, black jacket, blue jeans, approximately 22 years old.” She later said that this is what the youth told her and denied that this description came from her or from Constable Cross’ own observations of Mr. Pruden and the youth while they were in the stolen car. The youth told the Commissioners that he had not given the officers any description of Mr. Pruden and had said the man was between 17 and 19 years of age.

Eventually, other members of the Winnipeg police located Mr. Pruden and arrested him. The news of his arrest was broadcast immediately. There was no suggestion that they did not have the correct person in custody or that there was a third suspect at large.

At approximately 2:37 AM, after hearing that the suspect had been arrested, Constable Cross started walking toward the location of the arrest. On his way, he encountered Mr. Harper near a park. He approached Mr. Harper and asked him for identification. Constable Cross told the Commission that he asked Mr. Harper for identification because he wanted to be sure the police had arrested the right person. He said the youth had told him and Constable Hodgins that the driver of the stolen car was wearing a black leather jacket, and he could see that Mr. Harper’s jacket was black.

Constable Cross told the Commission that Mr. Harper said he did not have to tell Constable Cross anything. Constable Cross said he told Mr. Harper that he matched the description of a suspect he was looking for involving the theft of a car and asked again for identification. Mr. Harper again refused and started walking past Constable Cross. Constable Cross then placed his hand on Mr. Harper’s upper arm as he walked past and turned Mr. Harper around. Constable Cross said he did not have grounds to arrest Mr. Harper and was not trying to arrest him but wanted to stop him to explain in more detail why he wanted to see Mr. Harper’s identification. Mr. Harper turned to face him, and Constable Cross put his other hand on Mr. Harper’s wrist. Constable Cross said that Mr. Harper pushed him, causing him to fall. As he fell, Constable Cross grabbed Mr. Harper, pulling Mr. Harper down on top of him. They struggled, and Constable Cross felt a tug on his holster. He reached down to grab his revolver. The revolver came out of its holster, with both his and Mr. Harper’s hands on it. The gun went off and hit Mr. Harper in the chest.

Constable Cross stood up, fell back, and took a moment to regain his composure before radioing for his partner and an ambulance at 2:40 AM. The two officers who were first on the scene testified that Constable Cross said, “He went for my gun, and I shot him.” Another officer said that Constable Cross said, “I approached him, I asked him for I.D., and he hit me, knocked me down and went for my gun, it came out and he got shot.” His partner, Constable Hodgins, said he told her, “He jumped me, Kath. I was on my back on the ground. He went for my gun.” The youth, who was in the back seat of the cruiser, said that when Constables Cross and Hodgins got in, Constable Cross said, “I happen [sic] to reach for my gun... It happened so fast, I pulled the trigger.” The youth also said he heard an older officer at the scene tell Constable Cross to say the gun went off accidentally, and Constable Cross agreed that he would.

The Commissioners concluded that Mr. Harper did not fit the description of the man who had fled the stolen car. Constable Cross had no grounds to believe Mr. Harper was a suspect. The law requires and Winnipeg police policy and training confirm that if a person refuses to give their name and there are no grounds for arrest, an officer has no right to grab or otherwise try to stop the

person from continuing on their way. Mr. Harper may well have been justified in using force to resist what may have amounted to an unjustified assault by Constable Cross.

Although it was impossible to determine exactly what led to the gun going off, Constable Cross' story changed repeatedly. Constable Cross acknowledged having his finger on the trigger and having pulled it. Mr. Harper never had any significant degree of control over the revolver. The Commissioners concluded:

Cross' first remark after the shooting—"He went for my gun and I shot him"—was not given sufficient consideration in the investigation that followed. Instead, the effort to protect Cross and to shift the blame to Harper took precedence. This effort precluded any objective determination of the facts. We believe that officers collaborated in preparing their notes, that at least one set of notes was rewritten completely, and that Cross was assisted over a lengthy period of time in preparing his written statement, all of which causes us great concern. We also are troubled that one officer would advise another to "say the gun went off accidentally." We have been left with the impression that an "official version" of what happened was developed. We are satisfied that version is inaccurate.

Unfortunately, we are not able to report on exactly what did happen at each stage of the confrontation. We can, however, conclude that it was Cross, through his unnecessary approach and inappropriate attempt to detain Harper, who set in motion the chain of events which resulted in Harper's death.<sup>37</sup>

The Commissioners also found that the officers did not follow proper procedure following the shooting and gave Constable Cross special treatment and consideration. Senior officers mishandled Constable Cross' revolver and other evidence, failed to fingerprint the revolver, allowed Constable Cross to speak with other officers, failed to make proper notes of their conversations at the scene, and failed to ensure the investigation was carried out properly. They did not properly question civilian or police witnesses to the shooting and accepted the written reports of officers instead of interviewing them. A Crime Division officer in the Winnipeg force, Sergeant Williams, was called in to interview Constable Cross. The Commissioners concluded that he and other officers assisted Constable Cross to carefully construct his statement so as to ensure he was not in any jeopardy. They also did not record the interview. The Commissioners concluded that the investigation was not a true investigation but rather was engineered to corroborate and reinforce Constable Cross' version of events. Supervising officers also failed to take responsibility for the investigation.<sup>38</sup> The Commission stated:

This was not an independent professional investigation. Those involved in all parts of this investigation were guided, at least to some extent, by the corporate, institutional goal of self-preservation which functioned to reach a conclusion that Cross, and therefore the department, had done no wrong.<sup>39</sup>

The Commission had subpoenaed the notebooks belonging to the officers involved in Mr. Harper's shooting and the subsequent investigation. The Winnipeg Police took the position that

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<sup>37</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume III, chapter 4.

<sup>38</sup> Several officers involved in the investigation told the Commissioners that Acting Inspector Kenneth Dowson was ultimately responsible for the Crime Division's investigation of the shooting. However, Inspector Dowson took his life the morning he was scheduled to testify at the Inquiry. The Commissioners were still able to draw some conclusions about the supervision of the investigation, saying, "It may well be that Inspector Dowson was nominally in charge of the investigation, but lines of supervision and communication appear to have been so ineffective that no one actually took responsibility for determining all the facts of this case."

<sup>39</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume III, chapter 5.

officers' notebooks were in the possession of individual officers and beyond their control, and the Police Association challenged the Inquiry's authority to subpoena those notebooks, along with other aspects of the Inquiry's authority. The Manitoba Court of Appeal required the police to provide photocopies of portions of the officers' notebooks "relating to the Harper matter."<sup>40</sup> In their Report, the Commissioners identified significant problems with the officers' use of their notebooks. One officer had completely rewritten his notebook to change information about the events, which he said he did because another officer identified "mistakes" in it. That officer also falsely stated under oath at the fatality inquiry that he had made those notes at the time of or shortly after the events. Other officers testified that they routinely spoke to their colleagues to obtain or clarify information before writing their notes and also checked radio communications records to identify the timing of events. The Commissioners noted that the Toronto Police Department had much more stringent rules regarding the content and process of recording notes, and notebooks remain the property of the department upon the officer's retirement.

There was a delay in informing Mr. Harper's family of his death, which the Commissioners attributed to problems finding his address. However, the Commissioners found the manner in which the notification was made to be disturbing. They concluded that the officer who told the family spent considerable time asking questions about Mr. Harper's alcohol consumption and behaviour when intoxicated.

The Firearms Board of Enquiry, which was made up only of members of the Winnipeg police, was convened to review the shooting six hours after it occurred. The following morning, it issued its report exonerating Constable Cross. It did so without having all relevant information. The Commissioners concluded that in this instance, the Firearms Board functioned only as a public relations exercise, to assist in corroborating Constable Cross' version of events.

The Winnipeg Chief of Police also made statements the day after the shooting and immediately after the Firearms Board of Enquiry report was issued. Both statements indicated that Mr. Harper had instigated the struggle and the gun had discharged in the course of the struggle. The Commissioners strongly criticized the Winnipeg Police Chief for making these statements, noting that the investigation was not complete and that these statements setting out the Chief's version of events effectively foreclosed the possibility of a proper investigation. "Only the most exceptional or reckless officer would have risked embarrassing the Chief by pursuing the case."<sup>41</sup> The Chief's conduct was "just the visible expression of an attitude which was prevalent in his department—an attitude that viewed the public image of the police department and the interests of one of its officers as more important than finding out the truth about the death of a citizen."<sup>42</sup>

The Report concluded that racism played a part in Mr. Harper's shooting. It also concluded that there was racism in the Winnipeg Police Force, noting evidence that officers had directed racial slurs at the Aboriginal men who stole the car and had made racist comments at the scene of the shooting, and that a racist joke was circulating in the department regarding Mr. Harper's shooting. The Chief had done little to address these incidents of racism and seemed untroubled by them.

In the conclusion of the Commissioner's comments on Mr. Harper's death and the events following his death, they stated:

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<sup>40</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume III, chapter 1.

<sup>41</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume I, chapter 6.

<sup>42</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume I, chapter 12.

Society requires capable and professional police forces. We sometimes impose upon them responsibilities that are burdensome and expectations that border on the unrealistic. For those reasons, we must understand and accept that on occasion errors will be made and mistakes will happen. We do not demand perfection from our police forces. At the same time we are entitled to insist that they perform their obligations and duties in a professional and responsible manner.<sup>43</sup>

### **Findings about the Manitoba Justice System**

After reviewing the deaths of Helen Osborne and J.J. Harper and the subsequent investigations, the Commissioners of the Aboriginal Justice Inquiry examined the overall experiences of Indigenous people in Manitoba's justice system. They found that although Indigenous people constitute 12% of the population in Manitoba, they constitute over half of the people in correctional institutions, which the Commissioners described as shocking. They concluded that this overrepresentation of Indigenous people in the jails and at every other point in the justice system is caused by systemic discrimination in the justice system, overt racism, and stereotyping by justice officials, as well as social inequality, poverty, and cultural oppression. These factors are in turn the legacy of colonialism and effects of the long history of efforts by Canadian government institutions to eradicate Indigenous peoples as distinct societies.

The Commissioners focused a chapter of their report on the experiences of Aboriginal women and children. They stressed the very high rates of spousal abuse and other forms of gender-based violence in Aboriginal communities in Manitoba. They also noted statistics demonstrating that most women endure between 11 and 39 episodes of abuse before seeking help, and will then seek help from a shelter rather than from police. Few reported cases ever lead to trial, and rarely lead to a jail term. Aboriginal women were discouraged from seeking help from the police because they heard from others of the lack of sensitivity and understanding police had demonstrated about abuse. At times, women who called police ended up themselves being removed from the home, leaving their children behind. The Commissioners stated:

[I]t is clear that women in abusive situations, particularly in isolated communities in northern Manitoba, do not feel confident in turning to the justice system. We were told that many abused Aboriginal women did not feel safe enough even to bring their personal stories before the Inquiry.<sup>44</sup>

Women in rural communities often waited for a day for police to respond, only to have the abuser driven down the road and released. There are no safe houses for women and children to escape to. "They may be forced to spend the night in the bush, or be forced to leave the reserve entirely." The Report noted that chiefs and council members, who are mostly male, often support male abusers, effectively chasing the women from their communities. The Commissioners strongly criticized the "unconscionable" failure of Aboriginal government leaders to deal with the problem of domestic abuse. They stressed that chiefs and councilors must take on the protection of women and children as a pressing responsibility, particularly on reserves. They also recommended the creation of more appropriate programs for abusers, more transition houses, and more initiatives within the justice system.

The Report also noted the importance of comprehensive responses to domestic violence. The Commissioners recommended the creation of abuse teams made up of officers and social

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<sup>43</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume I, chapter 12.

<sup>44</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume I, chapter 13.

workers trained in family violence response. The teams should respond to all domestic disturbance calls and make a report about the nature of any conflict and any issues that should be anticipated or considered in any subsequent attendance. The teams could also connect families to peacemakers or other support groups in the community. The abuse teams should monitor the progress of families. The Commissioners noted, “It is our belief that preventive policing by an abuse team may be able to catch volatile situations and deal with them before the violence escalates.”<sup>45</sup>

The Commissioners also noted the contrast in services provided to Aboriginal women compared to non-Aboriginal women. There were no Aboriginal shelters in the province, except for one in Winnipeg, no Aboriginal safe houses, and no Aboriginal second-stage housing. There were no shelters in reserve communities, requiring women to leave their communities. The Commissioners also noted that the typical police practice of encouraging the women to leave while the men stay in the home is wrong. Although short-term crisis intervention is often necessary, and in some cases, jail is appropriate, the Commissioners also learned that abused women wanted Aboriginally-designed and directed programs, which would emphasize healing within the family and would not exclude the abuser from the treatment process. The Commissioners noted that if an offender is likely to return to the community and family after serving a sentence, it is important to cure the problem of violence. This would include adequate, culturally-based programming for alcohol abuse (a common factor in intimate partner violence in Aboriginal communities), and a recognition of the sources of despair that lead to alcohol abuse.

Abuse of children, including sexual abuse, was shockingly common in Aboriginal communities. The Commissioners acknowledged the role of colonization, they noted that is not an excuse for the way Aboriginal women and children were treated. They described child abuse as the single greatest threat to the future of Indigenous people.

Police–Indigenous relations were the subject of significant scrutiny in the Report. The RCMP provided policing services in most of the rural and Aboriginal communities in the province. Winnipeg, Brandon, and eight smaller municipalities had their own police forces. There were some Indigenous communities that had local, Indigenous-controlled police forces, but the majority of Indigenous communities were policed by predominantly white RCMP or municipal police forces.

The Commissioners identified significant problems with over-policing (harassment, charging and detention of Indigenous people by police in situations where white people would not face the same response) and under-policing (a lack of police presence in Indigenous communities except to make arrests, a focus on crime investigation rather than prevention, failure to enforce laws which protect Indigenous communities, and slow response times when police are called). RCMP members took advantage of Indigenous people, for example, by threatening to hold them in custody until they give statements. At the same time, they refused to investigate injuries and deaths of Indigenous people, or investigated them with less vigour.

The Commissioners identified the history of the RCMP in Manitoba as a significant cause of the suspicion and hostility Indigenous people felt toward police in communities across the province. The RCMP’s predecessor, the North-West Mounted Police (NWMP), was created to control the Indigenous population in the western and northern parts of Canada as they entered Confederation. This force was the main instrument for carrying out the repressive government policies of the time. They moved Indigenous people to reserves, ensured they stayed there,

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<sup>45</sup> “Report of the Aboriginal Justice Inquiry of Manitoba,” volume I, chapter 13.

administered treaties, and assisted Indian agents to enforce government policies regarding Indigenous people. They captured and returned children who ran away from residential schools and apprehended Indigenous people who left their reserves without a pass. There were some positives: Indigenous people were apparently grateful that the NWMP suppressed the whisky trade and prevented massacres by settlers against members of their communities.

Although the NWMP did not cause the North-West Rebellion of 1885 and warned the government of the need to address the increasing unrest, the NWMP was required to join military forces to suppress the rebellion. They arrested the rebels, a number of whom were hanged in the Mounted Police stockade. Authorities, including members of the Mounted Police, looted and burned the homes of Indigenous people, confiscated property, withheld annuities from bands who had participated in the rebellion, and virtually wiped out the Métis as a distinct political group. The Commissioners found that memories of this treatment lingered in many communities and affected Indigenous peoples' perceptions of other police forces. While members of the dominant culture recognized police forces as entities established to protect them and maintain their social structure, Indigenous people considered the police to be a foreign presence that did not operate on their behalf.

The Report did note that there were some communities in Manitoba where Indigenous people had very positive relationships with police officers. These tended to be in areas where the officers had become involved with the community after staying for a considerable length of time. As well, although there were significant problems with cross-cultural understanding and with the recruitment of Indigenous people to the RCMP, the RCMP had made efforts to improve Indigenous recruitment and had required significantly more cross-cultural training than other forces. The Commissioners expressed concern that financial pressures might lead more municipalities in Manitoba to abandon RCMP contracts and develop more local forces, which under Manitoba law had no standards or requirements for training at all. Forces in Winnipeg and Brandon had also struggled to recruit Indigenous members, although Brandon's force had established an innovative cross-cultural exchange program with the Dakota Ojibway Tribal Council Police Force.

### **Findings about Police Governance**

The Report identified significant problems with the governance of police in Manitoba. The Manitoba Police Commission was responsible by law for evaluating police forces, advising municipal forces, recommending training standards, and making recommendations on communications, equipment, and other matters. However, the Police Commission had only two staff and could not carry out its legislated responsibilities. The authority to appoint officers was fragmented over several pieces of legislation. Unlike other provinces, there were no provincial standards for training, qualifications, or equipment, and no provincial training facility.

Complaints about municipal forces were handled by the Law Enforcement Review Agency (LERA). The Inquiry Commissioners identified significant concerns with the LERA, including undue influence by police chiefs in resolving complaints about and determining penalties for their officers, lack of transparency, and delay in resolutions. There was also an unfair burden placed on complainants, who were required to prove misconduct beyond a reasonable doubt, without counsel, while officers had counsel.

Complaints about RCMP officers were handled by the RCMP Public Complaints Commission (PCC), which was established following two separate public inquiries into the RCMP. The PCC was made up of members from each jurisdiction in Canada that used the RCMP for provincial

policing. All these members were chosen by the federal government. No current RCMP members could be appointed to the Commission. The Inquiry Commissioners were highly critical of the PCC. Among the subjects of its criticism was the process whereby any complaint to the PCC was first investigated by the detachment itself, often by the very officer complained of. The onus was then on the complainant to pursue the matter to the PCC. The PCC could then determine that the RCMP investigation was satisfactory and do nothing; ask the RCMP to investigate further; or conduct its own investigation and/or institute a hearing. Officers could be compelled to testify. The PCC then sent a report with findings and recommendations to the parties, minister, and RCMP Commissioner. There was no requirement for the RCMP to follow these recommendations. There was no appeal, and there was no requirement for a hearing. The Inquiry Commissioners noted that the PCC was physically remote from Manitoba, particularly for Aboriginal communities, and drew the following conclusions regarding its process:

The system is not independent, because the RCMP have such an overwhelming influence over the entire process, including power to dismiss the complaint, control the conduct of the investigation and power to disregard the findings of the commission.

We find the process to not be in the public interest. Rather, it appears to be a process designed to protect the RCMP and to leave all its decisions to its own officers, at one level or another.<sup>46</sup>

The Inquiry Report reviewed a number of alternate approaches to addressing public complaints against members of police forces. It noted that in Ontario, prior to legislative reforms in the 1990s, outside police forces had sometimes been called in to investigate police conduct issues. The Commissioners stated:

This was found to be an inadequate solution. It is true that the appearance of independence is enhanced when an outside police force is asked to investigate particular situations, but the appearance of independence is still compromised when police investigate police, especially when police forces must work so closely together on a day-to-day basis to provide good policing.<sup>47</sup>

The Commissioners recommended that the RCMP institute a process similar to the Ontario Office of the Public Complaints Commissioner, which was designed to be fair and independent, with full powers to impose penalties, including dismissals.

The Report's other recommendations on policing focus on the adoption of Aboriginal community-based policing, with regional Aboriginal police forces reporting to Aboriginal communities; the creation of Aboriginal police commissions to support those forces; improvements to employment equity programs, particularly for the Winnipeg and Brandon police forces, in order to ensure that Aboriginal people are substantially represented among the members of the forces; cross-cultural training, particularly to orient new staff to Aboriginal communities; significant work on police standards and procedures in Manitoba; and an effective public complaints body to address policing-related complaints.

### **Implementation of Recommendations**

The Report included a chapter on the implementation of its recommendations. Numerous participants in the inquiry process had expressed fear that the resulting report and

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<sup>46</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume I, chapter 16.

<sup>47</sup> "Report of the Aboriginal Justice Inquiry of Manitoba," volume I, chapter 16.

recommendations would “placed on a shelf to gather dust” and never be acted on. The Commissioners acknowledged that the extent to which their recommendations would be implemented would depend on their persuasiveness, the degree of support in Aboriginal and non-Aboriginal communities, the willingness and capacity of both the Manitoba and federal governments to make the recommended changes, “and their overall responsibility to govern in a manner that takes into account the interests of all members of society.”<sup>48</sup> The Commissioners set out guidance for the implementation of their recommendations and also recommended the establishment of an implementation commission. This Aboriginal Justice Commission, as the Commissioners referred to it, would have a board of equal numbers of Aboriginal and governmental representatives, along with an independent person agreeable to all parties as chair. It would be independent of government, with the responsibility of monitoring the implementation of the recommendations and reporting publicly on that progress. It could also facilitate negotiations between governments and Aboriginal people, and assist in resolving disagreements. This Commission could also monitor the results of any recommendations that were implemented, such as affirmative action programs.

Eight years after the release of the Report, the Aboriginal Justice Implementation Commission was created to develop a plan to implement the recommendations within the jurisdiction of the provincial government. It issued its Final Report in 2001 with recommendations to promote the implementations of the AJI’s recommendations.<sup>49</sup> It also recommended the creation of a permanent Aboriginal Justice Commission. In an interview in November 2021, Murray Sinclair, Co-commissioner of the original Aboriginal Justice Inquiry, explained that the majority of the AJI’s recommendations had not been implemented due to pushback from institutions in society.<sup>50</sup>

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission<sup>51</sup>**

1. Culturally appropriate education, trades training, and counselling programs, particularly those having to do with the treatment of alcohol abuse, family violence, anger management and culturally appropriate ways for inmates to cope with their problems, be provided in every Manitoba correctional institution.
2. Aboriginal leaders establish a local government portfolio for women and children, with responsibility to develop educational and support programs in the area of spousal and child abuse.
3. Police forces establish family abuse teams which include police officers and social workers trained in dealing with domestic disputes. Such teams should make extensive use of electronic record-keeping and community resources.
4. Shelters and safe homes for abused women and children be established in Aboriginal communities and in urban centres. These shelters should be controlled by Aboriginal women who can provide culturally appropriate services.

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<sup>48</sup> “Report of the Aboriginal Justice Inquiry of Manitoba,” volume I, chapter 17.

<sup>49</sup> “Final Report of the Aboriginal Justice Implementation Commission” (November 1999), [http://www.ajic.mb.ca/reports/final\\_toc.html](http://www.ajic.mb.ca/reports/final_toc.html).

<sup>50</sup> D. Carreiro (2021) “30 Years after Aboriginal Justice Inquiry, Too Little Done to Protect Indigenous Women and Girls, Critics Say.” *CBC News* (15 November 2021), <https://www.cbc.ca/news/canada/manitoba/aboriginal-justice-inquiry-30-years-mmwig-1.6247285>.

<sup>51</sup> Recommendations were unnumbered in the Report.

5. Community mediation programs such as the one operated by the Hollow Water Resource Group be expanded to Aboriginal communities throughout the province. Such programs must be designed and operated by Aboriginal people.
6. The federal and provincial governments provide resources to Aboriginal child and family service agencies for the purpose of developing policies, standards, protocols and procedures in various areas, but particularly for the purpose of developing computer systems that will permit them to communicate quickly and effectively with other agencies, to track cases and to share information.
7. Police forces adopt a community policing approach, particularly in Aboriginal communities.
8. Police forces immediately institute employment equity programs to achieve Aboriginal representation equivalent to the Aboriginal proportion of the Manitoba population
9. Cross-cultural education components of all police training courses be reviewed and strengthened, and this process actively involve members of the Aboriginal community, resource persons and recognized experts.
10. All police officers be rotated through cross-cultural education programs, and periodic refresher programs be provided as part of the regular professional development programs of all police departments.
11. Any police recruits displaying racist attitudes be screened out of training, and police officers who display such conduct after joining the force be required to take further training or, if necessary, be formally disciplined or dismissed.
12. All statements taken by police officers be either audio- or video-recorded.
13. As soon as possible, Aboriginal police forces take over from the RCMP the responsibility for providing all police services in Aboriginal communities.
14. The RCMP support the establishment of Aboriginal police forces and develop a policy of cooperation with such forces.
15. While they continue to police Aboriginal communities, the RCMP and all other Manitoba police forces develop and make public an integrated strategy to strengthen their capacity to provide culturally appropriate policing services, and the strategy include the development of a process of regular communication with Aboriginal organizations and communities, and the annual publication of reports which indicate progress in meeting the goals of the strategy.
16. The Dakota Ojibway Tribal Council Police Force be provided with sufficient resources so that it can increase staff training and development in modern police methods, and gradually assume full responsibility for all law enforcement duties within its geographic jurisdiction.
17. Aboriginal communities be encouraged to form regional police forces and regional police commissions following the model of the Dakota Ojibway Tribal Council Police Force. These should be established under Aboriginal control and management.
18. Metis and non-status communities consider the development of a regional police force, with a police commission.
19. New targets be set by the RCMP to bring appropriate numbers of Aboriginal men and women into the force as full officers more quickly than is currently contemplated.
20. The RCMP employ Aboriginal police and civilian staff in their detachments in proportion to at least the Aboriginal population of the province and preferably in proportion to the Aboriginal population being served.

21. The Winnipeg Police Department prepare and table with the city council and the Minister of Justice, no later than December 31, 1991, an employment equity plan which has clear targets, target dates and remedies should targets not be achieved.
22. The City of Winnipeg Police Department set an initial target of 133 Aboriginal police officers. The first step in reaching that goal should be to designate the next recruiting class as entirely Aboriginal. Thereafter, 50% of each recruit class be dedicated to Aboriginal recruits until the target has been met.
23. The Winnipeg Police Department be required to report publicly the progress of its employment equity program to the Minister of Justice.
24. A portion of the funding provided by the Province to the City of Winnipeg for police salaries be conditional on the Winnipeg Police Department's using that funding only for the hiring of Aboriginal police officers.
25. The assignment of Aboriginal police officers not be restricted to the core area or other Aboriginal areas of the city of Winnipeg
26. The Winnipeg Police Department no longer rely on the grade 12 educational criterion for police recruitment and develop approaches which more appropriately test recruits' ability to perform the functions required of police officers.
27. The City of Brandon Police Department prepare and table with Brandon City Council and the Minister of Justice an employment equity plan no later than December 31, 1991, which will increase the numbers of Aboriginal people on the City of Brandon Police Department to a level equal to their proportion of the Manitobapopulation. The plan should include target dates by which to achieve that proportion and remedies should those targets not be met.
28. The Brandon Police Department set an initial target of nine Aboriginal police officers and that the City of Brandon Police Department dedicate that number of positions for Aboriginal recruits in its next recruit class.
29. Both the City of Winnipeg Police Department and the City of Brandon Police Department consider hiring Aboriginal police officers who already have policing experience with an Aboriginal force or with the RCMP.
30. Aboriginal people be represented among the civilian members of both the City of Winnipeg Police Department and the City of Brandon Police Department in the same proportion as their presence in the province's population.
31. The City of Brandon Police Department, in cooperation with the Brandon Friendship Centre, develop a program to reach out to and inform Aboriginal people living in Brandon about policing issues.
32. The Provincial Police Act make explicit provision for the recognition of any police commission or committee which is established to provide police services in any municipality, unorganized territory, or Aboriginal community in Manitoba.
33. The Manitoba Police Commission prepare and enforce a wide range of regulations covering recruitment, training, equipment, procedures, supervision of, and support for, police forces in Manitoba.
34. The Provincial Police Act be amended to provide for the establishment of a provincial Aboriginal Police Commission with authority to prepare and enforce a wide range of regulations covering recruitment, training, equipment, procedures, supervision of, and support for, Aboriginal police forces in Manitoba.

35. Final decisions concerning the size, composition and manner of appointment to the Aboriginal Police Commission be made by Aboriginal people.
36. The Provincial Police Act be amended to provide for the appointment of an Aboriginal Police Commissioner, to serve the Aboriginal Police Commission, with any such person being selected by Aboriginal organizations responsible for Aboriginal police forces.
37. Agreements be developed between the provincial Aboriginal Police Commission, local police commissions, the RCMP and the provincial Justice department for Aboriginal police forces to provide full police services to Aboriginal communities, with a firm timetable for achieving this goal, including training, equipping and supporting the local forces with appropriate back-up services as required.
38. The Minister of Justice establish a plan of action to deal with any incident where possible criminal acts are alleged against the police, or where a person dies or suffers serious injury in an incident involving a police officer. This plan of action include either the creation of a standing special investigations unit, or a plan to quickly assemble a special investigations team for a particular incident, able to take control of the investigation immediately following report of the incident. The unit or team should not include officers from the police department under investigation. The plan should include independent counsel to give advice concerning the laying of criminal charges. This counsel should not be a Crown attorney. The unit or team should report directly to the Minister of Justice.
39. The police forces in the province be required to provide all available assistance and cooperation to the special investigations team.
40. The Law Enforcement Review Board be reconstituted and the Law Enforcement Review Act be amended to approximate the Ontario model.
41. The board appoint independent counsel to have conduct of each case and be responsible for presenting the evidence.
42. Where the complaint is from an Aboriginal person, one member of a panel be Aboriginal.
43. The test to be applied by the board be proof by clear and convincing evidence, rather than beyond a reasonable doubt.
44. If the board decides that the complaint is proven, it have full power to impose whatever penalties it deems appropriate.
45. In addition to what is now in the Law Enforcement Review Agency reports, the agency report annually on the nature of complaints, how many were found to have merit, how many were dismissed and the type of penalty applied.
46. Police officers, including the officer against whom the complaint is made, be compellable witnesses.
47. Aboriginal justice systems establish and maintain an agency to receive, investigate and resolve complaints against Aboriginal police officers similar to what we recommend for provincial police forces.
48. Complaints against the RCMP in Manitoba, when acting as a provincial police force, be investigated and heard by the Law Enforcement Review Board.
49. An Aboriginal Justice Commission of Manitoba be established by legislation and by appropriate processes of the Aboriginal people of Manitoba, with a board of directors made up of equal numbers of Aboriginal and government representatives, and an independent chairperson. The commission should be provided with all necessary staff and resources.

50. The position of Aboriginal Justice Commissioner be established as the chief executive officer of the Aboriginal Justice Commission. The commissioner's tasks will include monitoring and assisting government implementation of the recommendations of this Inquiry.
51. Governments consult with Aboriginal groups to design and implement a data collection system that will provide detailed information to compare the impact on, and treatment of, Aboriginal and non-Aboriginal persons by the justice system, to evaluate the success of programs dealing with Aboriginal offenders and to provide information to help identify needed reforms.
52. As a matter of urgent importance, governments and Aboriginal people, with the assistance of the Aboriginal Justice Commission, negotiate an acceptable process to provide ongoing funding for Aboriginal governments to undertake the initiatives we suggest, in a manner consistent with:
  - a. The need of Aboriginal people for an ongoing, consistent revenue base.
  - b. The right of Aboriginal people, as original owners of the land, to a fair share of revenue resources from both levels of government.
  - c. The greater access to the revenue-generating powers and sources available to federal and provincial governments.

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### **2.2.2. Rebuilding the Trust: Federal Task Force on Governance and Cultural Change in the RCMP (2007)<sup>52</sup>**

The Task Force on Governance and Cultural Change in the RCMP was created by a federal Order in Council in 2007 and was led by David Brown, QC. It was prompted by an investigation into issues related to RCMP pension and insurance plans, which raised issues with the governance and culture of the RCMP. The Report also noted the public scrutiny of the RCMP following the September 2006 release of Justice O'Connor's report on the Maher Arar matter (summarized below in section 3.4.), the Air India Inquiry then underway,<sup>53</sup> and the October 2007 death of Robert Dziekanski after he was tasered by RCMP officers.<sup>54</sup> The Task Force completed its review in five months, consulting with thousands of RCMP members and employees across the country, as well as with federal departments and agencies engaged with the RCMP, federal and provincial Solicitors General and Attorneys General, and members of the public.

The Task Force concluded that "there is a need to radically overhaul the way the RCMP is governed" and to improve the accountability to the public, elected leaders and RCMP members and employees.<sup>55</sup> The Task Force members noted that given the complexity of the RCMP, it would not be unreasonable to conclude that breaking it up would solve some or all of the issues confronting it. However, they determined that this decision would require a much broader public

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<sup>52</sup> "Rebuilding the Trust: Report of the Task Force on Governance and Cultural Change in the RCMP" submitted to Minister of Public Safety and President of the Treasury Board (December 2007), [https://www.publicsafety.gc.ca/cnt/cntrng-cm/tsk-frc-rcmp-grc/\\_fl/archive-tsk-frc-rpt-eng.pdf](https://www.publicsafety.gc.ca/cnt/cntrng-cm/tsk-frc-rcmp-grc/_fl/archive-tsk-frc-rpt-eng.pdf).

<sup>53</sup> The final report of the Air India Inquiry can be found here: [https://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/air\\_india/2010-07-23/www.majorcmm.ca/en/reports/finalreport/default.htm](https://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/air_india/2010-07-23/www.majorcmm.ca/en/reports/finalreport/default.htm)

<sup>54</sup> The report of the Braidwood Inquiry into Mr. Dziekanski's death can be found here: <https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/about-bc-justice-system/inquiries/braidwoodphase2report.pdf>

<sup>55</sup> "Rebuilding the Trust," p. vii.

policy debate, beyond the mandate of the Task Force, and suggested that their recommendations should allow for the proper governance of the RCMP instead.<sup>56</sup>

The Task Force was not able to identify any police agency that provided the same range of services provided by the RCMP.<sup>57</sup> They consulted with experts on best practices in Canada and internationally and published a number of research papers provided by some of those experts.

The Task Force made the following findings:

1. The RCMP's organizational framework does not allow it to properly discharge its responsibilities. Its approach to governance is a "confusing mixture of traditional and modern ideas, philosophies, practices and programs,"<sup>58</sup> and reform will require a radical overhaul of its governance structure.
2. Responsibility for staffing the RCMP is split between the RCMP and Treasury Board, and the Treasury Board decides through its funding approvals how many members and employees and senior management positions are available, as well as the pay for each. The RCMP is also subject to human resource policies designed for the public service. The RCMP is unable to respond in a timely manner to staffing problems in regions or on specific projects. It has also failed to properly approach the aspects of human resource management it does control.
3. The funding mechanisms for the RCMP have become intolerably complex and restrictive, preventing the RCMP from properly allocating resources on a timely basis.
4. The RCMP's management structure is "a product of the military-bureaucratic policing model."<sup>59</sup> The resulting rank-based authority, with formalized, insular, and bureaucratic management by command and control, prevent the Force from delivering on its mandate. Collaborative decision-making and challenging of decisions are discouraged. "[W]e heard more than once that the culture is one of fear and intimidation and that some who are in a position of command use their authority to intimidate others." Those in charge at detachments and other units do not have authority to make operational decisions and must seek authority up the chain of command, seriously compromising their ability to police effectively.<sup>60</sup>
5. Discipline and grievance matters do not go to an independent, binding adjudicator, and there is little accountability for delays in the grievance process. The RCMP External Review Committee (ERC) makes recommendations to the RCMP Commissioner on certain types of grievances and appeals of formal disciplinary actions. Those recommendations are not binding on the Commissioner.
6. The process for investigating public complaints is not independent, easily accessible, transparent, or timely. The RCMP Public Complaints Commission (CPC), created in 1986, also makes nonbinding recommendations to the Commissioner. There is no mechanism for analyzing complaints and grievances to identify and respond to widespread problems.

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<sup>56</sup> "Rebuilding the Trust," p. ix.

<sup>57</sup> "Rebuilding the Trust," p. x.

<sup>58</sup> "Rebuilding the Trust," p. 1.

<sup>59</sup> "Rebuilding the Trust," p. 5.

<sup>60</sup> "Rebuilding the Trust," p. 41.

7. The common bond between police officers created by their work in a dangerous occupation, their dependence on each other, and their contact with often violent law breakers, creates a “culture of policing.” That culture can contribute to effective and responsible policing. However, it can also lead officers to react negatively to complaints about their conduct. Although internal police investigations are usually done professionally, full civilian oversight is necessary to ensure public confidence in investigations of police conduct.<sup>61</sup> “In order for citizens to have confidence in their police, they must have confidence in those who ensure accountability of police to the public.”<sup>62</sup>
8. The RCMP operating model is not sustainable. It is increasingly unable to satisfy the expanding demands for policing services, putting untenable pressure on RCMP members. The issues at the RCMP must be addressed by a management team; that management team must be properly in control of the agenda of the RCMP. The RCMP “must learn to stand tall in its interaction with its stakeholders. It must take pride in its accomplishments and humbly accept its shortcomings. It must accept accountability.”<sup>63</sup>
9. The RCMP never operates at full capacity. At every detachment the Task Force visited, there were unacceptable vacancy rates, often 25–30%. When a new position is created, it typically takes two years for it to be filled due to the recruitment and training process. The policing contracts do not permit the RCMP to replace members who are absent due to leave, secondment, or suspension. Remote and isolated posts are in particular danger of being seriously understaffed. Frontline officers are burdened by administrative obligations due to the increasing complexity and formalization of investigations. New data collection systems require time consuming data entry. This can deter officers from pursuing an investigation at the end of a shift. Fatigue and burnout can also impair judgment, which can expose members to danger. “The culture must not reward—even implicitly—work habits that do not promote good mental and physical health.”<sup>64</sup> Members are also underpaid for overtime.
10. RCMP members believe that managers do not abide by the Force’s values of honesty, integrity, compassion, respect, accountability, and professionalism.<sup>65</sup> The discipline process for members is overly legalistic and adversarial. Performance evaluations were not routinely performed and were not used to plan training or make promotion decisions.
11. There is insufficient funding for management training or research and development on police methods.<sup>66</sup>
12. There are systemic weaknesses in communications, both to the public and from management to members, including slowness, lack of transparency, and inaccurate information. A complete review of the RCMP public affairs and communication function is necessary. “A crisis management process should also be developed with a view to improving the timeliness and quality of information to senior management for decision-making and quick and accurate responses to the media and Canadians.”<sup>67</sup>

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<sup>61</sup> “Rebuilding the Trust,” p. 13.

<sup>62</sup> “Rebuilding the Trust,” p. 14.

<sup>63</sup> “Rebuilding the Trust,” p. 23.

<sup>64</sup> “Rebuilding the Trust,” p. 27.

<sup>65</sup> “Rebuilding the Trust,” p. 29.

<sup>66</sup> “Rebuilding the Trust,” p. 37.

<sup>67</sup> “Rebuilding the Trust,” p. 40.

13. There is too much central control over contract policing, in contrast to the local authority of their counterparts in Ontario, Quebec, and local forces such as the Halifax police.<sup>68</sup> Local commanders need to have more operational authority, particularly around resource deployment. Given the importance of local relationships between ministers/mayors and local Commanders, provincial and local authorities should have more involvement in the establishment of policing objectives in jurisdictions where the RCMP provides contract policing services.
14. There is inadequate planning and local resourcing for the implementation of policies established by RCMP Headquarters. The divisions, districts, and detachments should be permitted to interpret and apply Headquarters' policies appropriately for the local conditions, with periodic reviews to ensure consistency.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 4) The organizational needs of the RCMP must be assessed against its current and future commitments. The RCMP must have the financial resources to satisfy all of its current contract and federal policing responsibilities and the ability to commit resources to satisfy those responsibilities within a reasonable planning horizon.
2. (Recommendation 14) Senior management of the RCMP must ensure that ethics principles underpin all management and administrative functions and are an integral part of all policing activities.
3. (Recommendation 15) The methodology applied to ethics training provided to recruits at the Depot should be extended throughout the organization and should be continually reinforced and refreshed.
4. (Recommendation 31) The RCMP needs to demonstrate greater openness and willingness to accept lateral entry into the Force in order to provide needed specialized skill sets and experience. In the longer term, the Task Force believes that the RCMP should also make a post-secondary degree a condition for all new recruits.
5. (Recommendation 32) The RCMP must recommit to education and training that will equip its officers for senior responsibilities. Leadership training should be a continuum throughout the member's career. The RCMP should identify deserving members with potential for further education and support them in seeking post-secondary education.
6. (Recommendation 33) The RCMP must rebuild its research capability in order to provide members of the Force with an opportunity to explore developments in law enforcement outside of the RCMP and stay abreast of modern policing methods.
7. (Recommendation 39) The RCMP should review and further develop its public affairs function, implementing a public affairs plan that contains a comprehensive internal and external communications strategy that keeps stakeholders appropriately informed. It should also include a crisis management strategy that will permit quick and accurate responses to the media and Canadians.
8. (Recommendation 40) The Force should ensure that, throughout the chain of command, internal communication is a fundamental responsibility for every person in a leadership position.

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<sup>68</sup> "Rebuilding the Trust," p. 42.

9. (Recommendation 41) The RCMP should examine and review its approval authorities to ensure that those closest to operational police activity have the requisite authority to make decisions in a timely manner.
10. (Recommendation 42) Headquarters should give greater weight to the views and priorities of contracting authorities and should involve them in a more meaningful way in decisions that have an impact on their jurisdictions.
11. (Recommendation 47) The government should immediately appoint the Implementation Council having the composition, mandate and other attributes set out in Chapter 5.
12. (Recommendation 48) The RCMP should form an internal change management team comprised of members and employees to be engaged full time in planning, coordinating and implementing the changes recommended in this Report. Although leadership will necessarily be provided by senior management, continuous engagement of members and employees at all levels will be essential.

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### **2.2.3. Kingsclear Public Interest Investigation Report (Commission for Public Complaints Against the RCMP, 2007)<sup>69</sup>**

The New Brunswick Training School in Kingsclear, New Brunswick, was established in 1962 as a custodial facility for youth in conflict with the law. It also served as a temporary residence for children in need of protection who were awaiting foster placement. The school was within the RCMP's area of responsibility for criminal investigations. The school closed in 1998 following the conviction of a former staff member of sexual offences against school residents. In 2004, the Commission for Public Complaints Against the RCMP (CPC), the predecessor organization to the Civilian Complaints and Review Commission, received complaints from seven former residents about the RCMP's investigation of sexual and physical assaults, and commenced this investigation.

In October 1985, a staff member, David Forbes, reported to the Fredericton Police that three Training School residents alleged that a staff member, Karl Toft, had perpetrated sexual assault. Mr. Toft was transferred to another institution, and the RCMP was not notified. In 1998, Mr. Forbes told an acquaintance who worked for the government that he had reported a guard at the school for sexually assaulting residents, and nothing had happened. As the CPC noted, this disclosure "was the first in a series of events that launched one of the lengthiest criminal investigations in the legal history of New Brunswick," exposing "a sordid and tragic series of events and crimes" that affected numerous people and spanned almost 40 years.<sup>70</sup> In 1990, the Attorney General of the province directed the RCMP to investigate these allegations. None of the three boys who were believed to have been victims were willing to testify. The RCMP and Crown agreed that without their testimony, a conviction was unlikely. No charges were laid.

Over the following two years, the RCMP and Fredericton police forces conducted parallel investigations into Mr. Toft. Mr. Toft was charged with a total of 37 offences. He pled guilty to these charges in October 1992. Later that year, the RCMP created a special unit to locate other victims and suspects. In 1993, the RCMP recommended 32 more charges against Mr. Toft,

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<sup>69</sup> "Kingsclear Investigation Report: Public Interest Investigation into RCMP Investigations of the New Brunswick Training School." Commission for Public Complaints Against the Royal Canadian Mounted Police, 2007, <https://www.cccc-cctep.gc.ca/en/archived-kingsclear-investigation-report>.

<sup>70</sup> "Kingsclear Investigation Report," p. 25.

relating to 26 victims. The Crown eventually decided it would not be in the public interest to proceed with those charges.

In 1992, the RCMP began investigating rumours about a New Brunswick RCMP officer, Staff Sergeant McCann, who was stationed two hours from Kingsclear. Sgt. McCann admitted that he knew Mr. Toft but denied any wrongdoing. The lead investigator decided that the rumours about Staff Sgt. McCann's conduct were based on assumptions about his access to potential victims. "[I]n order to protect Mr. McCann", he placed the file in a sealed envelope that could only be accessed by senior RCMP staff. Staff Sgt. McCann's name was also blacked out of all statements. The lead investigator later learned that Staff Sgt. McCann had taken a particular witness out on passes several times. The witness said Staff Sgt. McCann exposed himself to him but did not want to get involved. This witness' mother later told the investigator that Staff Sgt. McCann had sexually assaulted the boy. The lead investigator subsequently completed a report indicating that no reasonable and probable grounds existed to lay any criminal charges against Staff Sgt. McCann. Staff Sgt. McCann retired from the RCMP in April 1993.

In 1998, two former residents alleged abuse by Staff Sgt. McCann. RCMP investigators told them that the offences were minor or summary conviction offences, for which the limitation period had passed, so nothing could be done. The investigation was reopened again in 2000. Seven former school residents disclosed sexual assault by Staff Sgt. McCann; four of these had earlier denied being abused. In 2002, the RCMP investigators provided the Crown with detailed briefs on each of these allegations. They also arrested and interrogated Staff Sgt. McCann, who made no incriminating statements. The Crown recommended that no charges be laid, since an acquittal would be more likely than a conviction. This assessment was based on concerns about the victims' credibility, including criminal records and substance use, lack of corroboration, issues with memory, and inconsistencies and contradictions in their statements. No charges were laid. That concluded the investigation.

The CPC did not substantiate the suggestions that the RCMP tried to cover up the allegations against Staff Sgt. McCann or any of the staff at the New Brunswick Training School or that senior RCMP officials had interfered with the investigation. The CPC found that the perception of members of the public had been influenced by rumours and by their lack of information about the steps the RCMP had taken during the investigation. For example, the RCMP was sufficiently committed to the investigation of Mr. Toft in 1993 that it was prepared to hire its own prosecutor had the Crown refused to go forward. (Charges were laid, but the Attorney General stayed those charges a week later.) The public was also not aware that the Crown in New Brunswick screens potential charges before they are laid and would not recommend laying a criminal charge unless convinced that a conviction is more likely than an acquittal. (In other jurisdictions, police do not typically consult with the Crown before laying charges, and the Crown's standard for assessing charges is "reasonable prospect of conviction" rather than "more likely to convict than acquit.") The RCMP investigation was also hampered by the reluctance of the victims to come forward, the time that had passed since the events, and difficulty obtaining school records.

However, the CPC found that there were inadequacies in the investigations into abuse at the school, which could have contributed to the public perception of a cover-up. These inadequacies included:

- A lack of due diligence by senior officers in "J" Division, given the sensitive nature and large scope of the investigation. It was known almost from the beginning that the investigation was sensitive, high-profile, and had the potential to develop into a large-scale investigation, yet few dedicated resources were allocated to it. It should have involved

greater scrutiny by management, and senior officers should have provided more direction and resources. With some exceptions, senior officers became involved only once there was media attention, when complainants communicated directly with them, or when government officials enquired about the progress of the investigation. In the early years, senior officers also did not appear to know about the investigation into Staff Sgt. McCann. As a result, no internal investigation into whether his conduct breached the RCMP code of conduct was ever opened.

- Inadequate resources, an issue that was raised by members from all levels. In the early years, only one investigator was typically assigned, rather than a pair or team, which led to delays while these officers investigated other files, and gaps and inconsistent investigative work as officers were transferred in and out of the detachment. Had the investigation been properly resourced, it would have progressed more quickly and with more professionalism.

The CPC also raised issues with the RCMP Commissioner's response to its interim report, noting that the RCMP Commissioner stated that resources are finite, referring to vacancy rates, staff turnover, and other factors. The CPC Commissioner noted that some of these difficulties related to the RCMP's role in contract policing and to their approach to staff mobility. He expressed concern that the RCMP Commissioner referred to these resourcing issues without making any commitment to try to change them. He urged the RCMP Commissioner to raise the resource issues directly with the provinces, territories, and municipalities who pay for RCMP contract services.

- Inappropriate deference to the opinion of the Crown when deciding whether to lay charges. Although New Brunswick police were required to consult with the Crown before laying a charge, the responsibility for laying charges ultimately lay with the police. Most of the RCMP officers interviewed by the CPC wrongly believed that they were required to accept the Crown's recommendation as to whether to lay a charge.
- Inadequate note-taking, report-writing, and documentation by some RCMP members. There were significant variations in the style and comprehensiveness of the officers' notes. Two interviews with Sgt. McCann in 1992 and 1998, for example, were very poorly documented, as were several conversations with Crown counsel. Poor note-taking may have affected the course of the investigation, for example when information about sources was inaccurate or illegible, and they could not later be located. RCMP note-taking policies were vague and largely unenforced. The CPC stressed the significance of these problems:

The impact of incomplete and deficient reports or notebooks is so great that the administration of justice may be affected as a result. With so many examples of inadequate reports or notes throughout the investigations, this is an issue that cannot be ignored.<sup>71</sup>

The CPC noted that RCMP policies governing notebook retention had changed markedly over the years, but members continued to be responsible for their storage. There was no policy regarding notebooks of members who retired, transferred, or resigned. Most other police departments had more stringent policies regarding notebooks. The RCMP practice of allowing its members to retain their personal notebooks caused difficulties for the CPC investigation. However, the vast majority of RCMP members were willing to cooperate with the investigation, and senior management intervened so as to enable the CPC to

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<sup>71</sup> "Kingsclear Investigation Report," pp. 269–70.

complete its investigation. (The report does not include details of these difficulties and interventions.)

In response to the CPC interim report, which detailed its findings on the note-taking deficiencies, the RCMP Commissioner promised to redraft its policy on note-taking and noted two new training initiatives focused on note-taking and report writing. The CPC said in response,

Neither previous policies dealing with note-taking, report-writing, and documenting nor the focused cadet training mentioned in the Commissioner's Notice have been successful in eliminating chronic problems in this area. The key element of any effective strategy to ameliorate compliance with note-taking, report-writing, and documenting policies should include an accountability mechanism whereby the RCMP identifies non-compliance and then provides directed remedial measures to the member. The RCMP might consider the practices of other police agencies which regularly assess adherence to their performance standards.<sup>72</sup>

- Staff Sgt. McCann received different treatment during two interviews than a civilian suspect would have, and those interviews were inadequate. The first interview, in 1992, was premature, as it took place before all potential victims had been interviewed. That gave Staff Sgt. McCann the opportunity to destroy evidence or contact potential witnesses. The interview was conducted by a single officer, who was of lower rank than Staff Sgt. McCann; it was not recorded; the officer did not take detailed notes and did not prepare a detailed report; the interview was held in Sgt. McCann's office; and the officer did not brief squad members or senior officers, either before or after the interview. The officer stated that he did not have any evidence at the time that would substantiate the rumours about Sgt. McCann, but he wanted him to be aware that the RCMP was investigating those rumours. However, given that he and the other officers continued the investigation after the interview and took significant steps to try to encourage victims to come forward, the CPC concluded that the officer was not attempting to give Sgt. McCann an advantage by holding this meeting.
- After the investigation into Sgt. McCann was renewed in 1998, the lead investigator and the officer in charge of the Major Crime Unit interviewed Staff Sgt. McCann in his home. The officers considered Staff Sgt. McCann a suspect but did not record the interview, take detailed notes, or write a report about the discussion. By interviewing him in his home, without taking a formal statement, the officers "gave the former RCMP member a consideration not generally accorded to suspects."<sup>73</sup> It also gave the impression that the officers were not taking the investigation seriously and contributed to public concern about the police investigating themselves.
- The Staff Sergeant leading the investigators refused suggestions from his team members to interview key witnesses. He also disregarded a behavioural profiler's suggestion that the second interview be conducted by a member of the same or higher rank as Staff Sgt. McCann. Some of his team members said he was keen to investigate, while others said he backed off of taking difficult steps. Had he taken those steps, the outcome may not have been different, but there would be less cause for concern about a cover-up.

The CPC report also commented on the RCMP's approach to communicating with the public. The RCMP did not develop any public relations strategy relating to the New Brunswick Training School

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<sup>72</sup> "Kingsclear Investigation Report," p. 2.

<sup>73</sup> "Kingsclear Investigation Report," p. 259.

investigations. It sent out a few press releases in response to stories in the media but did not regularly communicate with the public about the investigations. The CPC noted that the RCMP policy on communications and its guide for media spokespeople did not set out the lead roles and responsibilities in high-profile investigations or provide guidance on managing the public's expectations.

The CPC also noted difficulties relating to the decision to have the RCMP investigate one of its own members. The public's mistrust was inevitable in that context. Furthermore, despite the lack of evidence of a cover-up, it was the case that Staff Sgt. McCann had received preferential treatment during the two interviews in 1992 and 1998. The CPC said this about the impact of the RCMP having its own members conduct the investigation on its relationship with the media and the community:

A criminal investigation into allegations against a member of the RCMP is sensitive and high profile and should be afforded the highest priority. Like any police force, the RCMP is restricted in the amount of information it can divulge; however, this only adds to speculation that the matter is not being addressed as aggressively as it should.

In addition to being able to manage the investigations fairly, impartially, thoroughly and in a timely manner, the investigative team must also manage its relation with the media and, most importantly, with the affected community. As is evident from the various RCMP investigations into the NBTS and Staff Sergeant McCann, this is not easy. Although the public may not be aware of the inner workings of police investigations, it is the duty of the police to ensure that the public can understand the RCMP's actions. This can be achieved by assigning the investigation to an outside police agency or, at the very least, to an RCMP team from a different jurisdiction.<sup>74</sup>

The CPC Commissioner also expressed concern about the RCMP Commissioner's response to its findings on this issue. The RCMP Commissioner stated that policy development was underway to address concerns regarding member investigations of other members but provided no specifics.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. The CPC recommends that the Commissioner of the RCMP and RCMP commanding officers ensure that a mechanism is in place to identify investigations that may become sensitive or of a large scale or both.
2. The CPC recommends that appropriate response and accountability mechanisms be put in place at the senior officer level to enable senior officers to monitor continuously the progress of any sensitive or large-scale investigation and assure the public of transparency, effectiveness and impartiality.
3. The CPC recommends that an assessment and follow-up be conducted to determine the actual resource needs of the RCMP "J" Division to ensure that any sensitive and large-scale investigation is conducted without interruption and in a timely and professional manner.
4. The CPC recommends that the CO and senior members of the RCMP in a pre-charge screening province ensure that members clearly understand their role in the administration of justice vis-à-vis the Crown to preserve their independence.

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<sup>74</sup> "Kingsclear Investigation Report," pp. 270–71.

5. The CPC recommends that the RCMP examine, amend, and enforce the “Investigator’s Notebook” policy and all policies related to note-taking, report-writing, and documenting to ensure that the policies are operationally effective and that officers adhere to and are continuously trained according to the guidelines.
6. The CPC recommends that the RCMP examine the policy on notebook retention used by other police agencies to glean best practices applied across the country, especially for officers who are retired, transferred or who voluntarily resign.
7. The CPC recommends that the various issues associated with note-taking, report-writing, and documenting be addressed through various approaches, including training, policy revisions, internal oversight, and monitoring.
8. The CPC recommends that any sensitive or large-scale investigation into allegations which impact on the community’s trust in the RCMP should be tasked to another police service or, at the very least, to a team of RCMP officers from another region or province who would have the appropriate experience and who would be unfamiliar with the member under investigation. This would assist in limiting the perception of bias and ensure that public trust in the RCMP is maintained.
9. The CPC recommends that the RCMP improve its internal and external communication strategies for any sensitive or large investigation, adopting a proactive communications approach using modern technologies to clearly demonstrate transparency and the RCMP’s accountability to the public.

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#### **2.2.4. Police Investigating Police (Commission for Public Complaints Against the RCMP, 2009)<sup>75</sup>**

The Chair of the Commission for Public Complaints against the RCMP (CPC), the predecessor organization to the Civilian Review and Complaints Commission, conducted an investigation into criminal investigations of RCMP members involving serious injuries or death by other RCMP members between 2002 and 2007. This was prompted by public concern regarding two shooting deaths by RCMP members in British Columbia, the death of Robert Dziekanski, and the RCMP’s handling of investigations of alleged sexual abuse at the Kingsclear Youth Training Centre in New Brunswick. (The CPC had no role in conducting criminal investigations of RCMP members.) The CPC reviewed 28 RCMP investigations of members who were alleged to have caused serious injury, death, or sexual assault during the five-year timespan of the review. It also received public submissions, reviewed media, political, and academic debate on the issue of police investigation of police conduct, assessed the current RCMP policy on investigations of members, and researched alternative models. It also reviewed past inquiries into RCMP-involved deaths of civilians and related issues.

The literature review led the CPC to conclude that traditional models of police investigating police, with no civilian oversight, were no longer defensible. These models did not satisfy the public’s expectations for accountability and were not effective. Given the nature of criminal investigations, however, the CPC concluded that there must be some role for police. The CPC found that although there was little research on the subject of investigations of potential criminal conduct by police, particularly with respect to alternative models of investigation, the research that did exist

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<sup>75</sup> “Police Investigating Police: Final Public Report.” Commission for Public Complaints Against the RCMP. (August 2009), <https://www.crcc-ccetp.qc.ca/en/police-investigating-police-final-public-report>.

frequently recommended a model that includes police in the process of investigation, combined with vigorous civilian oversight.

Public submissions focused on the unacceptable delays in the conduct of RCMP investigations of its members, suggesting that delays are conscious tactics to prevent proper investigations and have a significant emotional toll on the subject members; the lack of transparency where the RCMP investigates its own members; suspicions of cover-ups and biased investigations; and perceptions of conflicts of interest arising when police forces investigate their own members.

The CPC noted that neither the Criminal Code nor the RCMP Act had any provisions governing criminal investigations of RCMP members. The RCMP Commissioner's Standing Orders required members investigating other members to "take the same action as you would for any other person" and to inform the Criminal Operations Officers (CROPS). Only three provinces (Ontario, Alberta, and Saskatchewan) had legislation addressing the investigation of police.

The CPC reviewed all RCMP policies drafted between 2001 and 2008 relating to police investigations of police. Where the RCMP had geographic jurisdiction, these policies required the appointment of an independent investigator for certain types of incidents, such as deaths in custody. Some of the provincial policies recommended the transfer of the investigation to a different police force entirely, but this transfer was discretionary. There were also very limited situations in which an administrative review was required. For example, where an RCMP Emergency Response Team caused serious injury or death, an incident commander from outside the division was required to conduct an administrative review. The CPC also noted that different jurisdictions defined "serious injury" differently. There were other inconsistencies in both the content and application of policies across divisions. The CPC said,

The sheer volume and variety of RCMP policies with implications for the issue of police investigating police is overwhelmingly large ... This police "overload" poses a great threat to the RCMP's operational effectiveness. The very nature of frontline policing requires that direction be provided in a format that is clear, concise and easy to access.<sup>76</sup>

The CPC made the following findings about the investigations it reviewed:

- 25% of the primary investigators knew the subject member, and 4% were from the same detachment; this was the case in both remote/northern regions and in more centralized divisions.
- More than half of the investigations had only one investigator assigned, which could create the potential for a conflict of interest, and many were of the same or lower rank as the subject member, creating the potential for intimidation.
- Investigations of serious allegations were often handled by members without significant experience, and general investigation service (GIS) members were not given any workload relief for these investigations, suggesting that the allegations were not taken seriously.
- However, all witnesses who were willing to cooperate were interviewed, and experts (such as accident reconstruction personnel) and resources were used appropriately.

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<sup>76</sup> "Police Investigating Police," p. iv.

- Most investigations were complete within six months, but 19% took longer than a year to complete, usually due to workload issues.
- Charges were laid in five of the 28 cases, resulting in convictions in two of the cases. The remainder were stayed, withdrawn, or resulted in an acquittal. Only one case went to trial.
- In all 28 of the investigations reviewed by the CPC, the reviewers found that the investigations were conducted professionally, conscientiously, and without bias. (The report noted that in one of these cases, a judge had determined that the subject members had in fact committed police brutality.)

The CPC identified three forms of investigations of police officers: 1) dependent, in which officers from the same detachment or from another detachment or force conduct the investigation without civilian involvement or oversight (the traditional model); 2) the interdependent model, in which either a civilian observer is assigned to the investigation to ensure that the police conduct it appropriately or a civilian body is involved in the investigation either directly or through an oversight mechanism; and 3) the independent model, in which a civilian body conducts the entire investigation with no involvement by police. At the time of the CPC report, there were memoranda of agreement between the RCMP and local police services in Nova Scotia, Newfoundland, and New Brunswick to allow those other forces to investigate RCMP members. However, the report noted that although these agreements can create the perception of independence and fairness, and allows for experienced investigators with appropriate resources to conduct the investigation

...the use of an external police force for member investigations remains highly discretionary and inconsistently applied across RCMP divisions. Having an external police force investigate the RCMP may provide only the appearance—but not the reality—of an independent investigation. Many seriously question the possibility of independence for external police investigations due to occupational and cultural police philosophies which can jeopardize the protection of the individual member thereby undermining the integrity of the investigation (e.g. “blue wall,” “blue curtain” or “code of silence”). There is also little evidence that external police officers do actually obtain higher levels of police cooperation from other police in complaint investigations to justify their involvement, and without public oversight external investigations of this nature often produce similar findings to an internal investigation and result in a low level of substantiated complaints.<sup>77</sup>

With respect to the interdependent model, the CPC described the work of the Independent Observer Program in British Columbia and Yukon, which assessed the impartiality of RCMP investigations of members. Although there were benefits to this model, the observers cannot conduct their own investigations, and because they are civilians, they may be viewed as illegitimate and unqualified by some police officers. The other option for the interdependent model involves the civilian oversight agency directly in investigations. The civilians collaborate with the investigating police force and may manage the investigation or assume control of it. The civilian investigators may include retired or seconded police officers, as well as civilians. This model combines the expertise and powers of police with independent and impartial civilians. It may, however, introduce police culture and values that could affect the development of a civilian culture. Alberta’s Serious Incident Response Team and Saskatchewan’s Public Complaints Commission both operate using this model.

The independent model does not involve police officers in the investigation of their colleagues, and there is no investigative collaboration between officers and the civilian body. An example of

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<sup>77</sup> “Police Investigating Police,” p. 78.

this approach was the Special Investigations Unit then in place in Ontario. The independent model creates total independence and accountability and may result in better cooperation from complainants. In some cases, the independence of the model may benefit the police in terms of its public reputation. The CPC concluded that this model is expensive and may be seen as undermining police management authority and responsibility. Police may assume the investigators are unqualified, ignorant of operational realities, and unsympathetic to police, and may resist cooperating with this process. That in turn could lead to failed investigations and a lack of public trust in the process.

The CPC was of the view that police should be involved in the process, but it recognized the need for enhanced civilian involvement in investigations in order to ensure their impartiality and integrity. It therefore recommended the interdependent hybrid model. Under this approach, an RCMP Review Body would be established and would have the authority: to refer the criminal investigation of an RCMP member to another police force or criminal investigative body in Canada; to monitor any criminal investigation of an RCMP member, where it deems it appropriate, which could include embedding an observer where the investigating body gives permission; and to undertake joint investigation with other police investigative bodies (such as provincial agencies mandated to investigate provincial or municipal police members). The referral of the investigation of a member to another force or investigative body would be mandatory in certain cases, depending on the seriousness of the alleged conduct.

Specific recommendations addressed the approach to be taken by RCMP members when investigating their own members, including the rank of the investigating officer, the use of teams, consultation with the Crown, and the use of administrative reviews. The CPC also recommended that policies and training be changed to reflect this approach and recommended the creation of a manual for RCMP investigations of their own members.

The CPC also recommended the establishment of a Registrar to collect data on member investigations and share that data with the CPC; monitor and ensure compliance with policy; manage an RCMP advisory group to advise on responses in sensitive cases; and create and maintain a mobile critical incident team of trained investigators on standby, ready to be deployed where appropriate. The CPC recommended it have a significant role in the new approach to member investigations, including having a CPC civilian observer embedded in the mobile critical incident team, and having the CPC Chair and Registrar jointly determine whether the mobile team should be deployed.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission<sup>78</sup>**

1. It is recommended that CPC legislation be modified to create a new RCMP Review Body with the mandate to refer the investigation of an RCMP member to a police force other than the RCMP or to another criminal investigative body in Canada.
2. The new RCMP Review Body should be responsible for determining when the monitoring capacity should be applied. (Discretion would lie with the RCMP Review Body and not with the RCMP, as is currently the case.)

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<sup>78</sup> This list has been compiled from several different parts of the report "Police Investigating Police," most notably pp. 97–102 and pp. 106–7. The order here is therefore not reflective of the original recommendations, many of which were not numbered.

3. The new RCMP Review Body should be granted the authority to monitor any criminal investigation relating to a member of the RCMP, where it deems it appropriate to do so.
4. The new RCMP Review Body should be granted the authority to undertake joint investigations with like-mandated bodies.
5. We recommend the creation of the position of National RCMP Member Investigation Registrar responsible for providing the CPC Chair with regular monthly reports for all member investigations undertaken for indictable offences, hybrid offences, and summary convictions. The Registrar shall:
  - a. Create an RCMP National Registry for all police investigating police data (especially for serious injury, sexual assault, and death cases) with timely sharing of data with the CPC;
  - b. Create and manage an RCMP Police Investigating Police Advisory Group to help determine actions to be taken in sensitive cases;
  - c. Monitor effective compliance with policy and enforce compliance where necessary (e.g. consultation with Crown re: laying of charges mandatory);
  - d. Create and oversee a specialized unit with expertise on the handling of RCMP historical cases to be consulted or deployed where necessary; and
  - e. Create a mobile critical incident member investigation team (with a CPC civilian observer embedded) that can be deployed where both the RCMP National Registrar and the CPC Chair jointly determined it necessary to do so (a pool of qualified senior investigators placed on standby that can be deployed quickly, e.g., peacekeepers).
6. The RCMP Commissioner should revise the current version of his Standing Orders to:
  - a. Include new Standing Orders to direct handling of member investigations, as per the recommendations in this report;
  - b. Specify that member investigations are not to be handled like any other criminal investigation and must therefore follow strict procedures set out for member investigations; and
  - c. Specifically revise current section 9 (“A member shall not investigate a complaint where that member may be in a conflict of interest situation.”) It is recommended that the term “conflict of interest” be further defined.
7. The CPC recommends that the rank of the primary investigator must be at least one rank higher than that of the subject member.
8. In order to reduce the length of time to conduct statutory investigations against RCMP members, it is recommended that member investigations be assigned to a team of (minimum) two members in a specialized investigative unit.
9. The RCMP should assign competent senior investigators with a proven track record in court who have completed the appropriate courses (e.g., sexual assault, major crime, interviewing and interrogation techniques, and statement analysis) who can effectively interview witnesses with strong analytical skills.
10. Workload of members assigned to member investigations should be reassigned or adjusted to prioritize member investigations accordingly.

11. Special attention should be paid to enforce the RCMP requirement to consult with the Crown prior to laying any charges against members, given the particular need for independence and impartiality in member investigations. The RCMP should also undertake a review regarding recommendations made to the Crown in cases involving RCMP members.
12. Given the sensitivity and transparency required for member investigations, it is recommended that administrative reviews be undertaken in all cases of serious injury, sexual assault, or death.
13. The RCMP should consider applying the use of the “probe” [a review designed to help determine how to proceed in less serious investigations] to lower-end investigations in all divisions.
14. The RCMP could consider recommending that the Officer in Charge of the Criminal Operations Section be the appropriate recipient of the probe report in order to determine whether or not a lower-end investigation should proceed to a statutory investigation.
15. Historical cases require expertise not typical of most investigators. It is therefore recommended that these types of cases be handled by a specialized unit at the national or regional level.
16. Policy guiding criminal investigations of RCMP members should be standardized nation-wide. This would allow for the statutory investigations into RCMP members to be conducted uniformly across the country.
17. The RCMP should formalize a memorandum of understanding for every division across the country to ensure consistency in the referral of member investigations to an external police service.
18. The RCMP should create an Integrated Manual to specifically address procedures for investigations undertaken by the RCMP into one of its members.

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### **2.2.5. Braidwood Commission on the Death of Robert Dziekanski (British Columbia, 2010)<sup>79</sup>**

Robert Dziekanski, a 40-year-old Polish man, travelled by air from Poland to Vancouver in October of 2007. He was lost in the Vancouver airport for several hours and became agitated. He did not speak English. Four RCMP officers responded to calls about Mr. Dziekanski and used a conducted energy weapon (Taser) on him several times. Mr. Dziekanski died at the scene. The Province of British Columbia appointed Thomas Braidwood, a retired judge of the British Columbia Court of Appeal, to conduct two public inquiries: the first into the use of conducted energy weapons in British Columbia, which was released in July of 2009;<sup>80</sup> and this report, which focused on the actions of the Vancouver airport staff, border security officials, first responders, and the RCMP officers. It was released in May of 2010.

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<sup>79</sup> “Why? The Robert Dziekanski Tragedy: Braidwood Commission on the Death of Robert Dziekanski,” submitted to the Attorney General of British Columbia (May 2010), <https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/about-bc-justice-system/inquiries/braidwoodphase2report.pdf>.

<sup>80</sup> “Restoring Public Confidence: Restricting the Use of Conducted Energy Weapons in British Columbia.” Report of the Braidwood Commission on Conducted Energy Weapon Use, submitted to the Attorney General of British Columbia (July 2009), <https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/about-bc-justice-system/inquiries/braidwoodphase1report.pdf>.

Mr. Dziekanski's intention was to permanently move to Kamloops, BC, where his mother lived. He spoke only Polish. He had never flown before and was anxious before the flight. However, his behaviour on both of his flights to Canada was uneventful. After his arrival, he stayed in the airport's customs area for several hours. He may not have understood where to go due to the language barrier. His mother, who had arranged to meet him at the airport, sought assistance from various airport staff to find him over the course of several hours. Eventually, at the suggestion of a Canadian Border Services officer, she returned to Kamloops. Two Border Services staff later came upon Mr. Dziekanski and assisted him through the immigration process. Mr. Dziekanski was approved for immigration to Canada. Mr. Dziekanski was cooperative during this process, although tired and thirsty. He went to the public meeting area of the airport shortly after midnight and appeared in security footage to be looking for someone, presumably his mother. Members of the public and airport workers described him as upset, nervous, angry, distraught, sweating, and talking to himself. At one point, he hit the glass doors in an attempt to get back into the lounge. People tried to speak with him but could not, due to the language barrier. Mr. Dziekanski used his suitcases and a chair to form a barrier, and a bystander's video showed him smashing a small table against a glass wall and throwing a computer on the floor. None of his conduct was directed at other people. People in the public area called 911 and the airport's Operations Centre. The Operations Centre called the RCMP at 1:23 am and reported there was a man, apparently intoxicated, who was throwing suitcases and chairs around.

A few minutes later, four RCMP officers arrived. The officers observed that Mr. Dziekanski was disoriented, agitated, sweating, unkempt, and breathing heavily. He was calm and cooperative with his hands at his side. One of the officers asked for his passport and mimed to explain. A bystander's video showed that Mr. Dziekanski moved slightly toward his luggage, a movement Mr. Braidwood interpreted as an effort to comply with the demand for his travel documents. However, the senior RCMP officer in the group, Cpl. Robinson, sternly and authoritatively said, "No. Stop." Mr. Dziekanski stopped moving and stood with his arms at his side, looking at the officers. Mr. Braidwood again concluded that Mr. Dziekanski was trying to comply and that Cpl. Robinson's direction that he stop was inappropriately aggressive and unnecessary. Mr. Dziekanski threw up his hands, turned away from the officers, and moved toward a nearby counter. Cpl. Robinson moved closer behind him. Mr. Dziekanski said in Polish, "Leave me alone. Leave me alone! Did you become stupid, or have you gone insane? Why?" The officers described his behaviour as defiant and resistant, justifying deployment of an intermediate weapon or device, as did two use-of-force experts who testified at the inquiry. Two other use-of-force experts were of the view that Mr. Dziekanski was acting out of frustration because he was receiving contradictory instructions from the officers. Mr. Braidwood concluded that Mr. Dziekanski was neither resistant nor defiant.

Mr. Dziekanski then turned and faced Cpl. Robinson, stepped backward, and picked up a stapler that was on the counter. Cpl. Robinson pulled out his baton and directed Cst. Millington to deploy the conducted energy weapon. At the same moment, Cst. Millington independently decided to deploy the weapon. Cpl. Robinson and Cst. Millington testified that they deployed the conducted energy weapon because Mr. Dziekanski had assumed a combative stance, was clenching the stapler in his raised fist, and stepped toward the officers, causing them to believe he intended to attack. Mr. Braidwood concluded that Mr. Dziekanski was simply holding the stapler and did not brandish it or move toward any of the officers.

Mr. Braidwood noted the restrictions that prevent public inquiries from making findings of criminal or civil liability. He said:

It is not my role as Commissioner to pass judgement on whether or not Cst. Millington was justified under s. 25 of the Criminal Code in deploying the conducted energy weapon in these circumstances. That is a legal determination properly left to the Criminal Justice Branch of the Ministry of Attorney General and to the courts. Indeed, it is not open to a provincial commission of inquiry to make findings of criminal or civil liability, and I have no intention of doing so.

Having said that, I think it is appropriate for a commission of inquiry to go beyond a mere recitation of the facts and to analyze the officers' actions in the context of the factual circumstances they faced, the training they had received, and the RCMP's policies under which they operated. I am authorized to make findings of misconduct if I consider it necessary to do so and to make recommendations on any aspect of my mandate. Analyzing the officers' actions and drawing conclusions from them are prerequisites to these two functions.

In my view, Cst. Millington was not justified in deploying the conducted energy weapon against Mr. Dziekanski, given the totality of the circumstances he was facing at that time. Similarly, Cpl. Robinson was not justified in instructing him to deploy the weapon. Further, I do not believe that either of these officers honestly perceived that Mr. Dziekanski was intending to attack them or the other officers.<sup>81</sup>

Justice Braidwood also commented on the RCMP training and policy on the use of force. He noted that the two use-of-force experts who were of the opinion that the officers' conduct was justified were responsible for training RCMP and other police officers on the use of force. Justice Braidwood commented:

While I consider Cst. Millington's decision to deploy the weapon and Cpl. Robinson's instruction to do so to have been unjustified in the circumstances, with horrendous consequences, I am equally critical of the policy and training paradigm that fosters such poor decision-making. This case cannot be dismissed as two officers having exercised poor judgement through an incomplete risk assessment that discounted Mr. Dziekanski's emotional state. The force-centric analysis they applied to the circumstances they faced appears to me to have been entirely predictable, given the similarly blinkered approach taken by [the use of force experts] Sgt. Fawcett and Cpl. Gillis in their evaluations and analyses.

I interpret the expert testimony of these two senior and experienced officers as reflecting the use-of-force training that occurs within the RCMP at large and in BC's municipal police departments. If that is so, it troubles me greatly. It is without a doubt essential that officers be trained in the use of force because many situations they face will require the use of force to protect the public and themselves and to restore public order. But that is only half the story. Many situations can be and should be resolved without force, and the skills and techniques that facilitate the non-physical resolution of such incidents should be an integral part of not only use-of-force training but also post-incident evaluations and analyses.<sup>82</sup>

Cst. Millington deployed the weapon for six seconds, causing Mr. Dziekanski to scream and fall to the floor. (The officers testified that Mr. Dziekanski did not fall and that the first deployment of the weapon had not worked. Mr. Braidwood rejected that evidence and found that Mr. Dziekanski fell as a result of the first deployment of the conducted energy weapon.) One second later, Cst. Millington deployed the weapon again for five seconds. Mr. Dziekanski was on the floor screaming and thrashing his legs. The officers wrestled with him and handcuffed him. Cst. Millington deployed the weapon a third time during the struggle, again without properly assessing the risk

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<sup>81</sup> "Why? The Robert Dziekanski Tragedy," pp. 246–47.

<sup>82</sup> "Why? The Robert Dziekanski Tragedy," p. 251.

and without justification. Cpl. Robinson also pressed his leg against Mr. Dziekanski's neck without justification. Cst. Millington deployed the weapon twice more, for a total of 15 seconds, while the officers were trying to handcuff Mr. Dziekanski.

Mr. Dziekanski went unconscious. Cst. Bently requested an ambulance and then upgraded the call to Code 3 when he saw Mr. Dziekanski's face turn blue. When firefighters arrived, none of the RCMP officers were attending to or monitoring Mr. Dziekanski. Cpl. Robinson refused the firefighters' request to remove the handcuffs, saying Mr. Dziekanski had been violent. Mr. Dziekanski was unconscious, did not appear to be breathing, and firefighters could not find a pulse. Paramedics arrived and made repeated requests to have the handcuffs removed before the officers did so. Mr. Braidwood found that Cpl. Robinson's refusal to remove the handcuffs was unjustified. The paramedics were not able to resuscitate Mr. Dziekanski, and after twenty minutes, he was pronounced dead.

The four RCMP officers made their notes, and investigators from the RCMP Integrated Homicide Investigation Team ("IHIT") interviewed them later that morning. They testified that they did not discuss the events before giving those statements. However, Mr. Braidwood found that they did discuss the incident. They may not have colluded to fabricate a story, but "their discussions resulted in them giving surprisingly similar accounts of the incident that tended to misrepresent what had happened and tended to portray Mr. Dziekanski's actions in an unfairly negative light and their own actions in an unfairly positive light."<sup>83</sup> In his report on the use of the conducted energy weapon, Cst. Millington also deliberately misrepresented the actions of Mr. Dziekanski, saying that he swung the stapler wildly at the officers, raised his fist, and after the first Taser, moved toward the officers with his arms raised.

Mr. Braidwood said,

In my 23 years as a criminal defence lawyer and prosecutor and in my 16 years as a trial and appellate judge, I have had professional dealings with hundreds, if not thousands, of RCMP officers. Those dealings reinforced the respect I have had for the Mounties since my childhood. The RCMP is an iconic institution in Canada, and for nearly a century its officers have served their country and its citizens with integrity and bravery, often in harsh and dangerous circumstances.

The unprofessional manner in which Cst. Millington and Cpl. Robinson dealt with Mr. Dziekanski, and all four officers' less than forthright accounting for their conduct, has had repercussions that extend far beyond this one incident and well beyond this province—Mr. Dziekanski's death appears to have galvanized public antipathy for the Force and its members. That is regrettable. As I have said several times in this report and in my earlier one, the most important weapon in the arsenal of the police is public support.

During the past few years, several other high-profile incidents appear to have undermined public confidence in the RCMP. I cannot comment on these other matters, but I can comment about this one tragic case. At its heart, it is the story of shameful conduct by a few officers. It ought not to reflect unfairly on the many thousands of other RCMP officers who have, through years of public service, protected our communities and earned a well-deserved reputation in doing so.<sup>84</sup>

Three weeks after public hearings ended and shortly before oral submissions were due to start, the federal Department of Justice disclosed to the Commission an email between senior RCMP

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<sup>83</sup> "Why? The Robert Dziekanski Tragedy," p. 13.

<sup>84</sup> "Why? The Robert Dziekanski Tragedy," p. 269.

members. This email raised issues about the sequence of events (in particular, whether the officers had made a plan to use the conducted energy weapon on their way to the airport). Mr. Braidwood referred to the delay in disclosing this document as “appalling.”<sup>85</sup> Although Justice Braidwood did not explain the cause of the delay in his report, media reports recount counsel for the Department of Justice stating that the RCMP provided the email to the Department of Justice, but it was inadvertently overlooked.<sup>86</sup>

Mr. Braidwood reviewed the possible triggers of the cardiac arrest that caused Mr. Dziekanski’s death. He dismissed the suggestion that Mr. Dziekanski died from a condition known as “excited delirium” and found instead that although the precise cause of death may never be known, the multiple deployments of the conducted energy weapon and the physical altercation both played a role.

Mr. Braidwood criticized the RCMP’s media approach following the incident.<sup>87</sup> The RCMP’s senior media relations officer for British Columbia made statements to the public that were factually inaccurate, painting Mr. Dziekanski in an unfairly negative light (for example, stating that Mr. Dziekanski was being combative and that “the violence was escalating”). The media statements also asserted that Mr. Dziekanski was tasered twice rather than four times, as was being publicly reported. Responsibility for media relations then moved to the RCMP IHIT branch. When the RCMP became aware that these statements were inaccurate, it did not correct them. Eventually, immediately before the IHIT spokesperson testified at the inquiry, the RCMP made a statement to the media apologizing for how it handled public communications about Mr. Dziekanski’s death. The IHIT officers testified that they did not want to issue any public statements about issues that were pertinent to their investigation until the investigation was complete, which is why the earlier statements by the senior media relations officer were not corrected. However, Mr. Braidwood noted that the IHIT did make a public statement to correct rumours that RCMP members did not provide Mr. Dziekanski with any first aid.

Mr. Braidwood attributed the inaccuracies in the initial statements about the incident to the rush to inform the public about what had happened before ensuring the accuracy of the information. He also concluded that the decision not to correct those inaccuracies amounted to an error in judgment on the part of the IHIT officer responsible and resulted from a conflict of interest caused by the RCMP conducting the criminal investigation of its own members. Mr. Braidwood noted that any inaccuracies in RCMP statements about an incident in which the RCMP was not itself implicated would be accepted by the public as normal in the early stages of an investigation. However, because the police were investigating themselves, the public was understandably skeptical about the RCMP’s explanation for these inaccuracies and its decision not to correct them.

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<sup>85</sup> “Why? The Robert Dziekanski Tragedy,” p. 175.

<sup>86</sup> See “Newly disclosed RCMP email drops bombshell on Taser inquiry.” CBC News, June 19, 2009. <https://www.cbc.ca/news/canada/british-columbia/newly-disclosed-rcmp-email-drops-bombshell-on-taser-inquiry-1.795707>

<sup>87</sup> Mr. Braidwood noted that the federal Department of Justice had argued that the terms of reference for the inquiry did not permit him to address this issue. He disagreed, noting that the terms of reference were broad, and he also noted that there was an “intensely negative public reaction to the RCMP’s media response, which in my view had the potential to undermine public confidence in the RCMP. When public confidence in such an important institution (that polices more than half of our province) is brought into question, it is in my view one of the principal functions of a public inquiry to address that issue and report to the government and public on it.” “Why? The Robert Dziekanski Tragedy,” p. 357.

Mr. Braidwood noted that the Davies Commission of Inquiry<sup>88</sup> and the Civilian Complaints and Review Commission (see section 2.2.4 above),<sup>89</sup> among others, had called for a civilian body to investigate incidents during which police officers may have broken the law. He said the issue was not whether to move to a civilian system but what form it should take. He recommended it be structured similar to the Special Investigations Unit (SIU) in Ontario (which has since been replaced) and be responsible for investigating all police-related incidents that may involve contraventions of the law or that cause death or serious harm. Unlike the SIU, this body should eventually be staffed entirely by civilians, with no member having served anywhere in Canada as a police officer. He acknowledged that this aspect of his recommendation was controversial, with many in the policing community taking the view that only experienced police officers can conduct this kind of investigation competently. However, the investigators at Ontario's SIU were all former police officers, and a 2008 report by the Ontario Ombudsman found that they were "steeped in police culture."<sup>90</sup> The Alberta body responsible for investigating officer-involved deaths and other possible criminal conduct by police officers was staffed by civilian investigators. Mr. Braidwood concluded that it was possible to have a competent investigative body without hiring any former police officers to staff it. Moreover, doing so was, in his view, essential, given the public's concerns about the integrity of police-led investigations of police. He also recommended that a special prosecutor be appointed to screen charges and prosecute these cases.

Mr. Braidwood made recommendations to ensure that arriving passengers can be effectively tracked through the airport and commended the airport management for changes it had made to its emergency responses. He noted, however, that there was confusion over which body—the Vancouver Airport Authority, the RCMP, local firefighters, or the BC Ambulance Service—was responsible for the various aspects of the response. He suggested that these agencies develop a plan to deal with such incidents in the future.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission:**

1. (Recommendation 6) I recommend that the Vancouver Airport Authority, RCMP, Richmond Fire-Rescue, and BC Ambulance Service:
  - Work together in formulating a plan of action for dealing with police use-of-force incidents at the Vancouver International Airport that evolve into medical emergencies.
  - Train, with regular updates, their personnel on any such plan of action formulated by them, including live training exercises.
2. (Recommendation 7) I recommend that, within two years of this report being made public, the provincial Minister of Public Safety and Solicitor General report publicly and in writing to the Legislative Assembly on the extent to which the federal government and the Vancouver Airport Authority have implemented the recommendations contained in this report, and if one or more recommendations have not been implemented, the reasons why.

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<sup>88</sup> "Alone and Cold: The Davies Commission of Inquiry into the Death of Frank Paul," submitted to the Attorney General of British Columbia (February 2009), <https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/about-bc-justice-system/inquiries/daviescommission-interimreport.pdf>.

<sup>89</sup> "Police Investigating Police: Final Public Report." Commission for Public Complaints Against the RCMP. (August 2009), <https://www.crcc-ccetp.gc.ca/en/police-investigating-police-final-public-report> (summarized and discussed in section 2.2.4 above).

<sup>90</sup> "Why? The Robert Dziekanski Tragedy," p. 417.

3. (Recommendation 8) I recommend that:
- a. British Columbia develop a civilian-based criminal investigative body, which I suggest be named the Independent Investigation Office (IIO).
  - b. The IIO be mandated to investigate all police-related incidents occurring throughout the province in which:
    - “police-related incidents” include but are not necessarily limited to incidents:
      - in which a person dies or suffers serious harm:
        - i. while in the custody or care of a municipal police officer or RCMP officer, or
        - ii. the death or serious harm could be seen to be the result of the conduct of any municipal police officer or RCMP officer, or
      - which involve possible contravention, by a municipal police officer or RCMP officer, of:
        - i. any provision of the Criminal Code, or
        - ii. any other federal or provincial statute that, if the incident were investigated by a police officer, might in the minds of reasonable, informed members of the public undermine confidence in the police.
    - “serious harm” means injury that:
      - creates a substantial risk of death,
      - causes serious disfigurement, or
      - causes substantial loss or impairment of mobility of the body as a whole or of the function of any limb or organ.
  - c. The IIO be accountable to the Ministry of Attorney General.
  - d. The IIO be led by a director who is neither a current nor former police officer, appointed by Order-in-Council for a fixed, renewable term of five or six years.
  - e. No member of the IIO shall have served anywhere in Canada as a police officer.
  - f. Notwithstanding para (e), during the first five years of operations, the IIO may include as members former police officers, provided that:
    - they have not served as a police officer in British Columbia within the preceding five years,
    - they take no part in any investigation relating to a law enforcement agency in which they were employed,
    - they constitute no more than a minority of the investigators who are assigned to a particular investigation, and
    - their employment with the IIO expires by the end of the five-year transitional period.
  - g. To ensure the IIO’s unquestioned authority to act, its essential powers be entrenched in legislation, such as:
    - the IIO director and investigators have the status of peace officers,

- the chief constable or commanding officer of the RCMP of the jurisdiction in which a police-related death occurs must immediately advise the IIO of the incident,
  - pending arrival of the IIO at the incident scene, the chief constable or commanding officer of the RCMP must ensure that the scene is secured and that officers involved in the incident are segregated from each other,
  - officers involved in the incident must not communicate with each other about the incident, except as authorized by the IIO,
  - the IIO becomes the lead investigative agency, and the home police department or RCMP has no investigative responsibility or authority, except as granted by IIO,
  - a witness officer must promptly make himself or herself available for an interview with the IIO investigator and must promptly deliver to the IIO all notes, reports, and other investigative materials relevant to the incident, and
  - a respondent officer may be—but is not compelled to be—interviewed by the IIO and must in all cases promptly deliver to the IIO all notes, reports, and other investigative materials relevant to the incident.
- h. In every police-related incident assigned to the IIO, a special prosecutor be appointed in accordance with the Crown Counsel Act.
- i. The provincial Ombudsman have jurisdiction over the IIO.

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### **2.2.6. Sharing Common Ground: Review of Yukon's Police Force (2011)<sup>91</sup>**

Policing services in Yukon are provided by the RCMP “M” Division. Public confidence in the RCMP had been shaken by the tasing death of Robert Dziekanski at the Vancouver airport in October 2007, the acquittal of two RCMP officers in Yukon who had been charged with sexual assault, and the death of an acutely intoxicated man in custody in a Whitehorse detachment in December 2008. In response, the Yukon Minister of Justice established this review of Yukon's police force and appointed as co-chairs the Commanding Officer of “M” Division, the Deputy Minister of Justice, and a representative of the Council of Yukon First Nations. The review had an Advisory Committee made up of representatives of women's organizations, Aboriginal organizations, and other groups. They conducted public meetings across the territory and met with justice workers, social service providers, and RCMP staff, and made a special effort to engage First Nations citizens in the review. Part of the mandate was to “review the services provided by the RCMP to citizens who are in vulnerable positions, including victims of domestic violence and sexual assault, as well as individuals who are arrested and detained in custody.”<sup>92</sup>

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<sup>91</sup> “Sharing Common Ground: Review of Yukon's Police Force.” Submitted to the Minister of Justice and Attorney General of Yukon (2011), <https://yukon.ca/sites/yukon.ca/files/jus-sharing-common-ground-final-report.pdf>. The Executive Summary of this report, published separately, can be found here: [https://emrlibrary.gov.yk.ca/women's%20directoratesharing\\_common\\_ground\\_executive\\_summary.pdf](https://emrlibrary.gov.yk.ca/women's%20directoratesharing_common_ground_executive_summary.pdf)

<sup>92</sup> “Sharing Common Ground,” Executive Summary, p. 2.

The Co-Chairs reported the following with respect to the experiences of women with the RCMP:

Women's groups in Yukon are deeply concerned about shortcomings across the criminal justice system, social services and community dynamics that make women fearful of reporting physical or sexualized violence to the police. In many of the situations where police are involved, women are in vulnerable family situations and dealing with child custody, welfare, domestic violence and the dynamics of social isolation in small and remote communities. Some women do not feel safe in reporting their abuse and do not trust that they will be safe after making a disclosure. They worry that they will not be taken seriously, that they will not be heard, that their situation will not improve, or that they will not receive the assistance that they require. Most distressing is that we heard from some women who fear reporting crimes against them to the RCMP.

First Nations women are in a particularly vulnerable position—first, in relation to the gender bias that they frequently face when dealing with the justice system, and second, with respect to racism they often feel as a result of being First Nations. [...] Many First Nations women do not trust the RCMP. The struggles of aboriginal women with the police have been strongly associated with the denial of their rights, destruction of family structures and traditions, poverty, addiction and violence.

In cases of domestic violence, women reported being questioned by police officers as they were being driven to shelters for the choices they had made, for staying in an abusive relationship or for exposing their children to violence. These women feel some investigators do not understand that women may not be able to leave a relationship for many reasons, including economic dependence, fear of family or community reprisals, or the belief that the perpetrator will change and the violence will end.<sup>93</sup>

The Co-chairs found a loss of trust by many citizens in the ability of the RCMP to uphold its core values. Members of First Nations communities reported being ignored, intimidated, treated unfairly, and being subject to what they referred to as “second-class justice.”<sup>94</sup> First Nations citizens did not typically report complaints about this mistreatment.

The Co-Chairs also reported that “M” Division members feel that they are under-resourced and unable to meet the expectations of the communities and are often on call 24 hours a day, as are officers in many smaller southern communities in Canada.

The Co-Chairs concluded that to establish trust in the police in Yukon, there must be a strong focus on building relationships with community members. Citizens need to be more involved in establishing police priorities, goals and objectives, and there should be a local, responsive, and independent police complaint process.

The Government of Yukon reported on the implementation of the “Sharing Common Ground” recommendations in 2014.<sup>95</sup> At that point, the Department of Justice decided to end the project stage of the implementation and to incorporate incomplete recommendations into department workplans.

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<sup>93</sup> “Sharing Common Ground,” Executive Summary, pp. 5–6.

<sup>94</sup> “Sharing Common Ground,” p. 23.

<sup>95</sup> Sharing Common Ground: Review of Yukon's Police Force. Final Report on Implementation” (2014) <https://yukon.ca/sites/yukon.ca/files/jus-sharing-common-ground-implementation-final-report.pdf>

### Recommendations Relevant to the Mandate of the Mass Casualty Commission

1. (Recommendation 1.1) That the Minister of Justice establish a Yukon Police Council. The council will be chaired by the Deputy Minister, Yukon Department of Justice, and composed of six members appointed by the Minister, three of whom will be nominated by First Nations. The role of the council is to make written recommendations to the Minister and the Commanding officer of “M” Division on issues relating to the delivery of policing services in Yukon, including:

- establishing core policing values that reflect Yukon’s history and cultural heritage;
- ensuring that community needs and values are reflected in the policing priorities, objectives, programs and strategies of “M” Division;
- establishing policing practices and standards for “M” Division;
- ensuring that police services are delivered in a manner consistent with community needs, values and expectations;
- acting as a liaison between the community and “M” Division;
- participating in the selection of the “M” Division Commanding Officer; and
- receiving reports on matters that affect the administration of justice, including Annual Performance Plan updates, public complaints, use of conducted energy weapons, and updates on high profile matters.

The Yukon Police Council may meet with First Nations, municipalities, non-government organizations, or others in carrying out its duties, and will coordinate activities with national organizations such as Commission for Public Complaints Against the RCMP and the Canadian Association of Police Boards. The council shall meet quarterly or as required to complete its mandate. The council shall report annually to the Yukon Legislature and Yukon First Nation leaders.

2. (Recommendation 1.2) That First Nations, municipalities and “M” Division establish community-based processes—which may include creating a local community Advisory Committee or inclusion of this function in the mandate of an existing community body—to provide opportunity for community input into developing detachment Annual Performance Plans that reflect local priorities, and to provide a mechanism to coordinate policing and related services within the community and deal with other community policing matters, as appropriate.
3. (Recommendation 1.3) That “M” Division undertake a review of the Commanding Officer’s First Nation Advisory Committee. This review should consider the committee’s composition, member selection process and terms of reference and ensure that the work of the committee is coordinated with the Yukon Police Council.
4. (Recommendation 1.4) That the Department of Justice and “M” Division develop a communication strategy in consultation with the Yukon Police Council to improve citizens’ understanding of the role of the RCMP, citizens’ rights and responsibilities with respect to law enforcement, how the public complaints process works.
5. (Recommendation 1.5) That “M” Division establish a First Nations Relations Advisor who reports directly to the Commanding Officer “M” Division.
6. (Recommendation 1.6) That the “M” Division Commanding Officer meets with leadership of each Yukon First Nation at least once per year and with all Yukon First Nation leaders together as practicable.

7. (Recommendation 1.7) That “M” Division ensures that First Nations and municipal leaders are offered the opportunity to participate in the selection of Detachment Commanders, and are informed and consulted when members are transferred in and out of a community.
8. (Recommendation 3.1) That the Department of Justice and “M” Division establish a working group that includes Yukon First Nations, municipalities and women’s organizations, to review and make recommendations to the Yukon Police Council on:
  - the desired skills and attributes of RCMP officers being considered for selection to Yukon;
  - human resources policy related to recruitment of members interested in serving in Yukon, including suitability of cadets for service in Yukon;
  - policies and practices related to retention of members in Yukon;
  - policies around duration of postings to communities; and
  - the feasibility of creating specialized Northern duty qualifications, and investing in members who are interested in long-term service in the North.

The review should consider issues such as officer suitability, gender and First Nation balance, and appropriate relief coverage.

9. (Recommendation 3.2) That the Northern Institute of Social Justice (NISJ), in consultation with Government of Yukon, “M” Division, Yukon First Nations and women’s organizations, develop a training and development framework for RCMP members policing in Yukon. The framework should prepare members to provide policing services that are appropriate to Yukon citizens and should include information on:
  - Yukon history and First Nation culture;
  - dealing with vulnerable persons, including those who are acutely intoxicated, those with mental illness and those with FASD;
  - responding to domestic violence and sexual assault;
  - non-violent communication and de-escalation skills; respectful communications;
  - how to work effectively in high-visibility, high-impact environments;
  - supervisory and leadership training; and
  - wilderness training.

The NISJ shall report back to the Yukon Police Council.

10. (Recommendation 3.3) That First Nations and municipal leaders ensure that members are introduced to community leaders, service providers and provided with an orientation to the community. This orientation should include understanding of the community’s history, First Nation culture and language, and social context.
11. (Recommendation 3.4) That “M” Division develop a community policing mentorship program to enable experienced members to support the development of others.
12. (Recommendation 3.5) That “M” Division review its policies, practices and programs for identifying and responding to members who may suffer from compassion fatigue, vicarious trauma or other related psychological issues and to ensure that members have access to the professional services and support they require.
13. (Recommendation 4.1) That the Department of Justice and “M” Division establish an interagency working group including representatives from First Nations, women’s organizations and the Public Prosecutions Office, to develop a comprehensive framework for responding to domestic violence and sexualized assault.

The framework should include:

- the creation of an “M” Division domestic violence/abuse team with specialized training and skills;
  - consideration of specialized prosecution services;
  - clarification of the primary aggressor/dual charging protocols;
  - an update of the role of the Sexual Assault Response Team (SART);
  - clarification of victim service responsibilities, including victim assistance volunteers;
  - specialized training for “M” Division members and other front-line responders on sexualized assault and domestic violence that addresses child custody issues and the enforcement of civil order and other regulatory remedies; and
  - consideration of a legal advocate position to support women and/or a Yukon Court Watch Program.
14. (Recommendation 4.2) That the Department of Justice construct a secure assessment centre with appropriate 24-hour medical support in Whitehorse to accommodate individuals who are detained or arrested by the RCMP and require secure custody, including acutely intoxicated persons.
15. (Recommendation 4.3) That the Department of Justice, Emergency Medical Services, “M” Division and First Nations examine the feasibility of creating an intervention team consisting of a peace officer and an emergency medical service provider that would respond to calls for service involving acutely intoxicated people.
16. (Recommendation 4.4) That the Department of Justice and “M” Division establish an interagency working group consisting of representatives from the Women’s Directorate, the Department of Health and Social Service, Emergency Medical Services, First Nations, women’s organizations and Public Prosecutions Service of Canada to develop a comprehensive strategy for managing high-risk individuals who are frequent users and common clients of government services.
17. (Recommendation 4.5) That the Departments of Justice and Health and Social Services and First Nations lead an initiative and collaborate with “M” Division to ensure that citizens in Yukon have access to emergency victim support and social services on a 24-hour basis.
18. (Recommendation 5.1) That the Yukon Police Council, Government of Yukon, “M” Division, First Nations governments, municipalities and citizens continue the dialogue on policing to foster positive relationships between the RCMP and citizens towards increasing public confidence in the police service and reducing crime, including but not limited to these activities:
- planned updates on high-profile and serious matters;
  - creation of an annual gathering to honour citizens who contribute to public safety;
  - recognition of RCMP members for outstanding performance in building and maintaining community relationships;
  - invitations to community leaders to attend graduation ceremonies at depot; and
  - support of youth programming in the community
19. (Recommendation 5.2) That the Department of Justice, “M” Division and First Nations explore best practices and innovative methods of increasing the number of women and First Nations citizens involved in the delivery of policing services:
- developing a recruitment strategy to encourage female and First Nations citizens to enter the RCMP;

- working with the Northern Institute of Social Justice to develop a Yukon First Nations career orientation program to prepare citizens for RCMP training at Depot Division, or for other careers in the justice system; and
  - examining the feasibility of establishing a renewed special constable program, community safety officer program or similar initiatives.
20. (Recommendation 5.4) That “M” Division examine the operation of the police Operational Communications Centre as it relates to response to communities and consider any improvements to make it more responsive to communities.
21. (Recommendation 5.5) That Justice Canada, the Department of Justice, “M” Division and First Nations review different approaches to community and aboriginal justice in order to ensure all communities are offered the opportunity to implement community and restorative justice processes.
22. (Recommendation 5.6) That “M” Division conduct a resource review to assess whether the division has adequate resources to meet its priorities.
23. (Recommendation 7.1) That on receipt of the report the Minister of Justice shall meet with Yukon First Nation leaders to review its recommendations and receive their input into the development of the implementation strategy.
24. (Recommendation 7.2) That the Minister of Justice, in consultation with “M” Division, Yukon First Nations, municipalities and women’s organizations and service providers, prepare an implementation strategy for how to respond to the recommendations in the Report.
25. (Recommendation 7.3) That one year following receipt of the report, the Minister of Justice table a report annually in the Yukon Legislative Assembly and with Yukon First Nation leadership on progress in implementation of the recommendations of the Report, and that this report also be submitted to the RCMP National Aboriginal Policing Services Branch and the Commissioner of the RCMP.

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### **2.2.7. Independent Civilian Review into Matters Relating to the G20 Summit (Toronto Police Services Board, 2012)<sup>96</sup>**

In June 2010, the G20 held its annual summit in Toronto. Numerous public protests in the form of demonstrations and rallies took place, starting one week prior to the summit. Approximately 1,000 protesters were arrested, and there were allegations of police brutality towards the protestors.<sup>97</sup> The Toronto Police Services Board, which is responsible for the provision of adequate and effective police services in Toronto, commissioned the Honourable John Morden, OC, a retired judge of the Ontario Court of Appeal, to review the role that the Toronto Police Service (TPS) played and the effectiveness of its strategies during the summit. Mr. Morden also reviewed the

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<sup>96</sup> “Independent Civilian Review into Matters Relating to the G20 Summit: Executive Summary and Recommendations” (the “Morden Report”). Submitted to the Toronto Police Services Board (29 June 2012), [http://www.tpsb.ca/g20/REPORT\\_ICR%20Morden%20\\_executivesummary.pdf](http://www.tpsb.ca/g20/REPORT_ICR%20Morden%20_executivesummary.pdf).

<sup>97</sup> The Morden Report does not detail the concerns leading to the commission of the Independent Civilian Review. The Office of the Independent Police Review Director released a report in 2012 setting out its findings, including excessive force and arbitrary and unauthorized searches and detentions: “Policing the Right to Protest: G20 Systemic Review Report.” (May 2012), [https://www.oiprd.on.ca/wp-content/uploads/G20-Systemic-Review-2012\\_E.pdf](https://www.oiprd.on.ca/wp-content/uploads/G20-Systemic-Review-2012_E.pdf). See also “Toronto Police Say They ‘Regret that Mistakes Were Made’ in G20 Mass Arrests following Major Settlement.” *Toronto Star* (19 October 2020), <https://www.cbc.ca/news/canada/toronto/g20-toronto-police-regret-1.5767958>.

role of the Toronto Police Services Board in the planning for and policing of the summit. Mr. Morden released his report, known as the “Morden Report,” in 2012.

Mr. Morden explained that civilian oversight of police acts as a “check and balance against the legal powers society has given the police to enforce the law... Where society confers on a particular entity the power to use force to ensure compliance with the law, the need for a check and balance of that power is particularly vital.”<sup>98</sup> This oversight involves two elements: governance, which includes responsibility for developing the framework within which policing decisions and actions will take place and which ensures that the police fulfills its function under the law while respecting community norms; and accountability, whereby the conduct of police is reviewed and evaluated against those frameworks and norms.

Mr. Morden noted the significant role police boards play in civilian oversight:

The Police Services Act has empowered police boards, through their policymaking and resource allocation powers, to shape the way in which policing is done. Police boards are the intermediary between the police and the public, acting as a conduit to receive and impart information, providing a forum to ensure public sentiment makes its way to the ears of law enforcers and, ultimately, arbitrating interests in determining what is incorporated into the policies that guide the actions of the police. Where the police board fulfills these functions, the legitimacy that is so important to policing by consent rather than coercion is maintained. An effective governance structure ensures that decisions made and actions taken by the police are reflective of the community’s values.<sup>99</sup>

Prior to 1990, the Police Services Act (PSA) did not define the roles or responsibilities of chiefs of police or police boards. “Policy” was generally considered the purview of police boards, while “operations” were the responsibility of chiefs, and neither body was permitted to encroach on the other’s role. The 1990 amendments were clearly intended to change this approach. Under the amended Act, each police service board must determine, after consulting the chief, the objectives and priorities of the police service and must establish policies for its effective management. Chiefs are responsible for administering and overseeing the police force according to the objectives, priorities, and policies established by their boards. The only limit on the governance powers of boards is a prohibition on directing chiefs on specific operational decisions or the day-to-day operation of the police service. Boards are not prohibited from obtaining information or making suggestions to the chief about any aspect of policing operations. They are prohibited from interfering in the actual policing function but are required to shape the structure and environment in which those functions take place. This is a significant responsibility and consistent with effective civilian oversight.

The Toronto Police Services Board did make policies, as required by the Police Services Act, but some of these policies simply replicated the requirements for policies set out in the provincial regulation governing policing—stating that the Chief of the TPS must establish procedures and processes respecting the issue in question. These policies did not provide any guidance to the TPS on what those procedures and processes should include. As well, once the Chief created these policies and procedures, the Board did not review them. Mr. Morden noted that this approach was inconsistent with the Board’s oversight obligations. As well, the Board had not engaged in consultations with the TPS as intended under the Act and refrained from asking questions or making suggestions about operational matters. Mr. Morden found that this approach

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<sup>98</sup> “Morden Report,” p. 83.

<sup>99</sup> “Morden Report,” p. 82.

was wrong. He noted that when the police anticipate an event requiring police involvement, they can and should consult with the Board, both before and after the event, to determine the best policies and approaches and to deconstruct and learn from what happened. Mr. Morden made recommendations for a consultation protocol to govern the Board's interactions with the TPS Chief. Through this protocol, the Board could make recommendations but not directions to promote policing operations that are consistent with legal principles and community values.

Most of the Board's information about TPS operations was provided by the Chief during Board meetings. The Board would ask the Chief to brief it on specific issues and would not necessarily ask the questions it would need to in order to learn relevant information about the TPS operations. The Board had given the Chief very specific, limited questions about the TPS plans for the G20 summit, relating to budget, media relations, and human resources, and directed the Chief not to discuss operational issues. Mr. Morden emphasized the importance of a culture in which the Chief and the Board engage in cooperative exchanges of information about policing issues, including operational issues. As well, some Board members did seek more information about the TPS plans for the Summit but were criticized by the Board Chair for raising the issue. Mr. Morden found that the rest of the Board should have followed these members' example rather than criticize them.

### **Training of Board Members**

Mr. Morden also noted that the training of board members varies across the province, and in some jurisdictions, the only training is provided by the Chief of Police. Mr. Morden found it to be improper for Chiefs to be the only source of training, particularly on the legislative functions of board members. The PSA empowered the government to make regulations regarding the training of board members, but no regulations had been made. Given the importance and complexity of the Board's work, particularly in a large centre like Toronto, and given the varying backgrounds that the Board's members will likely have, they require a high level of training.

### **Command and Control during the G20**

The TPS had four months to plan for the G20, a process that would normally take two years. Five partner organizations (the TPS, the Royal Canadian Mounted Police, the Ontario Provincial Police (OPP), Peel Regional Police, and the Canadian Forces) formed an Integrated Security Unit (ISU) to manage security for the G20 Summit. The RCMP was the lead organization and had ultimate authority over all the security operations made by the ISU. The TPS failed to involve the Board in the planning, and the Board was not aware of any of the TPS plans for the event. It was also unaware that the RCMP had authority to direct the planning and could override TPS planning decisions, or of any other facts that would allow it to engage in any oversight of the TPS for this event.

One of the significant issues in the policing of the event involved the "Interdiction Zone" fence. This fence separated the site of the G20 Summit from the rest of the city. The RCMP had assumed jurisdiction over the Summit site, while the TPS was responsible for the rest of the city. The TPS was also responsible for protecting the Interdiction Zone fence and became overly preoccupied with that responsibility. That left the "Outer Zone" vulnerable to violence and property damage, and the TPS eventually lost control of the Outer Zone. The TPS requested that the RCMP take over command of the Interdiction Zone, but there was no plan in place for this transfer of command, and the RCMP did not agree to this request until twelve hours after the request was made. OPP site commanders were also deployed to the Outer Zone. Mr. Morden found that had the Board been involved in the planning, it would have emphasized the importance of TPS policing of the Outer Zone, which would have minimized the violence and damage in that area. The lack

of planning also created significant confusion as to who was commanding the RCMP and OPP site commanders after the transfer of command, and both OPP and RCMP site commanders reported that it was difficult to determine who was in charge. Mr. Morden said,

The more complex a police operation is the more essential it is that all of the police services involved have a clear understanding of the scope of their authority. The governing document that addresses this purpose should be clear, comprehensive, and sufficiently detailed. Given the size and complexity of the G20 Summit policing operation, these two gaps should have been addressed.

The Board received no information with respect to the command and control structure for the G20 Summit. Given its responsibility for the provision of adequate and effective policing in the City of Toronto, the Board should have sought sufficiently detailed information to be confident that mechanisms were in place to govern how the Toronto Police Service would give orders to the thousands of officers deployed to the areas under its command. In addition, given the multijurisdictional nature of the policing of the G20 Summit and the potential for police officers in the City of Toronto to become subject to the command of the RCMP, it was incumbent on the Board to understand what command and control structure was in place.<sup>100</sup>

### **Training and Policies on Mass Demonstrations**

TPS officers and the police officers from other jurisdictions who were deputized to assist during the G20 summit received specialized training on the skills and equipment they would be using during the event. Although the training was generally well done, Mr. Morden found that there should have been more emphasis on the Charter rights of demonstrators and the officers' responsibility to protect the exercise of those rights. The images and language used in the training also often suggested that the protestors would all be engaged in destructive, violent conduct and that the officers would need to be aggressive to control them. There should also have been more practical skills training, including scenario-based training on the powers of detention and arrest and the rights of civilians during detention and arrest. The TPS did not consult with the Board on the training or make the Board aware of concerns that the TPS training coordinator had regarding the sufficiency and delivery of the training. The Board also took no steps to learn about the training, despite knowing that officers from other jurisdictions would be attending the summit and would have to follow TPS policies.

Prior to the G20, neither the Board nor the TPS had a policy in place to thoroughly address mass, large-scale demonstrations. Mr. Morden noted that the policing of mass demonstrations is an increasingly important issue, deserving specific and comprehensive policies. The TPS also failed to consult with the Board or Ontario's Ministry of Correctional Services regarding the Prisoner Processing Centre it built to process detainees during the summit, despite never before having attempted to create an alternate to its normal processing facilities. This led to numerous problems: only one pre-booking officer was responsible for screening each prisoner, leading to a severe bottleneck; prisoners were held in pre-booking cells in restraints, with no access to lawyers or phones, overcrowding, and young people being detained without being able to contact parents or guardians. The delays caused the detention of some prisoners for more than the 24 hours permitted by law. There was also a high number of strip searches of prisoners.

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<sup>100</sup> "Morden Report," p. 17.

## Badges

Mr. Morden also expressed concern about the numbers of police at the summit who did not display their name badges. Many of them were from forces outside of Toronto who were not required to comply with TPS policy on badge-wearing. However, many were from Toronto, where the policy requiring badge-wearing was not given prominence in the Board's materials. Mr. Morden said,

The intentional non-wearing of a name badge by an officer carrying out his or her duties is an extremely serious offence. It is a fundamental breach of duty for police officers to remove their name badges so that they may exercise their powers with intentional anonymity. The inevitable effect is to undermine the public's trust in the police force, a trust that is essential to the provision of effective police services.<sup>101</sup>

## RCMP Cooperation with the Review

In the course of the independent civilian review, Mr. Morden requested access to documents pertaining to the G20 Summit from the Toronto Police Service, the Toronto Police Services Board, and the RCMP. The TPS and TPSB were very responsive and cooperative. However, despite repeated requests, the RCMP did not agree to produce documents to the Review until nine months after the request. Mr. Morden said, "While I appreciate the cooperation the RCMP ultimately provided to the Review in the production of documents, the stage at which it occurred caused delay in the ultimate completion of this Report."<sup>102</sup>

## Recommendations Relevant to the Mandate of the Mass Casualty Commission

- Recommendation No. 1: Improving the nature and quality of Board policies

The Board, the Chief of Police, and the Ministry of Community Safety and Correctional Services should engage in consultation with a view to devising a method of improving the general nature and quality of Board policies made under O. Reg. 3/99 and otherwise.

- Recommendation No. 2: Filing police service procedures and processes with the Board

All Toronto Police Service procedures and processes should be filed with the Board as a necessary step to strengthen the exercise of its monitoring and oversight responsibilities.

- Recommendation No. 3: Legal counsel to the Board

The Board should have its own counsel whose legal services are not available to either the Toronto Police Service or the City of Toronto.

- Recommendation No. 4: Information exchange between the Board and the Chief of Police on all subject matters

The Board and the Toronto Police Service should ensure that an open exchange of information on all matters of operations and policy is established and maintained. The purpose of this information exchange is to ensure that both the Board and the Toronto Police Service are aware of the details necessary to engage in consultation concerning Board policies and Toronto Police Service operational mandates. This exchange must permit a two-way transmission of information between the Board and the Toronto Police Service: the Board is to be made aware of all information relevant to its statutory role to determine "objectives,

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<sup>101</sup> "Morden Report," p. 27.

<sup>102</sup> "Morden Report," p. 43.

priorities, and policies” for policing in Toronto, and the Toronto Police Service is to be made aware of information that may assist it in commenting on policy options the Board is considering. In particular, this information exchange must include the provision to the Board of relevant operational information by the Toronto Police Service before operations actually unfold.

- Recommendation No. 5: The Board should create a policy that defines “critical points”

The Board should, in consultation with the Toronto Police Service, draft a policy that defines what will constitute a “critical point” in municipal policing and identifies criteria that will be applied in determining when a “critical point” has arisen. This policy will assist both the Board and the Chief of Police in determining when operational information should be provided to the Board in advance of the “critical point.” The Board should consider using the following definition of a “critical point”: a policing operation, event, or organizationally significant issue for which advance planning and approval at the Toronto Police Service’s command level is required. There should be clarity and consistency concerning the types of matters about which more detailed information, including operational information, should be provided to the Board by the Toronto Police Service. This policy should be reviewed by the Board with some frequency after it is established to ensure that it is enabling the Board to identify events and issues for which operational information should be provided in advance.

- Recommendation No. 6: The Board should determine appropriate objectives, priorities, and policies for major events, operations, and organizationally significant issues in which the Toronto Police Service will be involved

Where critical points in the policing of Toronto arise, the Board and Toronto Police Service should apply the consultation protocol and engage in a consultation about the major event/operation or organizationally significant issue at the earliest possible opportunity. The Board should be provided with relevant operational and other information in order to understand the details of the major event/operation/issue. The Board should then work with the Chief of Police to identify the mission, objectives, and priorities for the particular event/operation/issue, the achievement of which will result in the provision of adequate and effective policing in Toronto. Once the mission, objectives, and priorities have been defined, the Toronto Police Service must maintain the autonomy to develop and execute the appropriate operational plans. The Board should conduct a review of the Toronto Police Service’ operational plans to ensure that (a) they are consistent with the mission or objectives stated by the Board; (b) they are consistent with applicable Board policies; and (c) that no additional policies are required in order to provide guidance to the Toronto Police Service. Through this review process, the Board may provide recommendations to the Toronto Police Service where it believes that a particular aspect of the operational plan may result in the operational mission, objectives, and priorities not being achieved. The Chief of Police, however, must remain entirely free to accept or reject the Board’s recommendations.

- Recommendation No. 14: Board to obtain information concerning the command and control structure for multi-jurisdictional policing events

The command and control structure for the policing of a particular event has a direct impact on the manner in which police services will be delivered. When the Toronto Police Service is involved in a multi-jurisdictional policing event in Toronto, the Board shall require information from the Chief of Police concerning the command and control structure for the event. The Board shall also ensure that the command and control structure will enable the Toronto Police Service to adequately and effectively provide police services for the event and for the City of Toronto generally.

- Recommendation No. 15: The Board should record confidential Board meetings  
Properly recording discussion and information provided during Board meetings is critical. It ensures that an accurate record of the questions asked and decisions or recommendations made is preserved. The Board should institute a practice of audio recording all confidential Board meetings.
- Recommendation No. 16: The Board should develop a mechanism to ensure all Board members are canvassed in advance of pre-meeting agenda briefings  
The pre-meeting agenda briefings present a useful opportunity for the Chair and Board Staff to identify areas and issues that may be of concern or interest to the Board and that should be placed on the agenda and to work with the Chief and his staff to obtain information the Board requires. The Board should develop a mechanism that requires canvassing all members in advance of these briefings to identify questions or requests for information that can be conveyed by the Chair during the briefings.
- Recommendation No. 17: The Board should create a policy requiring open communication and sharing of information between all Board members  
The Board should develop a policy that sets guidelines for the exchange of information between Board members. Under this policy all Board members would be required to share, at the earliest opportunity, information he/she receives through informal communications with the Chief on a particular matter or issue that is before the Board or that otherwise falls within the Board's statutory role and responsibilities.
- Recommendation No. 18: Where time is of the essence for procurement, the Board must maintain a monitoring role  
While specific timing issues may require the Board to pre-authorize certain expenditures in order to hasten the procurement of equipment and other supplies, the Board should maintain an oversight role with regard to this process. Where time is of the essence and the Board decides to suspend or alter its usual procurement practices, the Board should establish a process that will ensure it receives relevant information from the Toronto Police Service regarding the purpose and justification of all expenditures.
- Recommendation No. 20: Board policies and Toronto Police Service procedures should apply to police personnel seconded to assist the Toronto Police Service in a joint operation  
Board policy and Toronto Police Service procedures should apply to external police officers seconded to assist in policing the city of Toronto where those officers are under the command and control of the Toronto Police Service. The home police services boards should be required to formally adopt the relevant Board policies and Toronto Police Service procedures as their own. In that regard, the Board should provide its policies and the Toronto Police Service procedures to the home police services board so that it can help ensure that its officers are familiar with these policies and procedures. If external police officers violate Board policies or Toronto Police Service procedures while carrying out their duties in assisting the Toronto Police Service, the home board or their complaints and disciplinary oversight body should have the authority to discipline those officers, thereby avoiding any jurisdictional dispute between the Board and the home boards.
- Recommendation No. 23: The Board should amend its information-sharing protocol with City Council  
The Board should amend its existing information-sharing protocol with City Council to include a mutual information-sharing mechanism. This mechanism should address the type of

information to be shared and the method and frequency for sharing such information. The Board should also work with City Council to develop a protocol that ensures there is a free flow of communication to and from the Board and City Council with respect to the policing of major events.

- Recommendation No. 24: The Board should, with the assistance of the Ontario Association of Police Services Boards, analyze the issues and concerns raised with respect to sharing confidential or classified information

Sharing confidential or classified information between different policing partners is a complex issue that requires further study. Accordingly, I recommend that the Board request that the Ontario Association of Police Services Boards examine this issue carefully and propose solutions that would ensure that sensitive information is protected without detracting from the requirement that municipal police services share relevant information with the police services boards.

- Recommendation No. 25: The Board should develop an information-sharing policy for major events

The Board should develop a specific information-sharing policy tailored specifically for major policing events. The policy should include a direction concerning the manner and frequency in which the information should be provided to the Board. Under this policy, the Chief of Police would be required to provide the Board with information at the earliest possible opportunity with respect to the following matters, at a minimum: the nature of the event; the policing, security, and other entities involved in planning the event; whether the Toronto Police Service is taking planning or operational direction from another entity; information about Toronto Police Service's proposed priorities and objectives; the need for any requests for legislative change to accommodate the Toronto Police Service's policing of [the] event; and information about specific policing strategies or techniques that may be used during the event itself.

- Recommendation No. 26: The Toronto Police Service and the Board should work together to develop the training materials for a major event

The Toronto Police Service should share information with the Board on the training being developed for officers participating in a major event. This information should include: the topics to be covered, an overview of the general content, and any potential issues or concerns raised regarding the sufficiency of the training materials. The Board should examine the information provided with a view to maximizing the overall effectiveness of the training materials and ensuring that the materials properly reflect existing Board policies. This examination should include an assessment of the methods of delivery of the training (e.g., e-learning, practical exercises, etc.).

- Recommendation No. 28: Board policy on the wearing of name badges and/or police badge numbers

The Board should express its policy on the wearing of name badges and/or police badge numbers in its standard policy format and include it in its catalogue of policies. The policy should require the chief of police to report to the Board on a regular basis concerning incidents of non-compliance with the policy.

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### 2.2.8. Police Encounters with People in Crisis: Independent Review (Toronto Police Service, 2014)<sup>103</sup>

In July 2013, a young man, Sammy Yatim, was shot and killed by a member of the Toronto Police Service (TPS). The following month, then-Chief William Blair of the Toronto Police Service asked the Honourable Frank Iacobucci to review the policies, practices, and procedures of the TPS with respect to officer use of lethal force, particularly during encounters with people in crisis (i.e., people needing urgent mental health care or people experiencing a mental or emotional crisis whose behaviour leads to calls for police assistance). The Professional Standards Unit of the TPS conducted a separate review of the conduct of the officers involved in the shooting of Mr. Yatim.<sup>104</sup>

Mr. Iacobucci and his team interviewed over 100 people with experiences or viewpoints on the issue of police encounters with people in crisis, including experts in the United States and United Kingdom. They also reviewed policies, procedures, reports, and academic papers; written submissions from stakeholders; and recommendations from Ontario coroners' inquests. A roundtable with mental health experts, lawyers, civil liberties experts, and policing advocates also informed the report.

Mr. Iacobucci noted that there are approximately 20,000 calls per year in Toronto involving a person in crisis. The vast majority resolve without incident. However, between 2002 and 2012, TPS officers had fatally shot five people identified by the TPS as "emotionally disturbed persons." During the same period, 22 other emotionally disturbed persons died during police encounters from other causes, including suicide, restraint asphyxia, drug intoxication, and cardiac arrest.

Mr. Iacobucci's analysis of the structure and resourcing of mental health services in Toronto led him to conclude that there is no "mental health system" in Ontario. Although addressing the significant problems with the treatment and prevention of mental health issues was beyond the scope of his report, Mr. Iacobucci stated that "there will not be great improvements in police encounters with people in crisis without the participation of agencies and institutions of municipal,

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<sup>103</sup> "Police Encounters with People in Crisis: An Independent Review Conducted by the Honourable Frank Iacobucci for Chief of Police William Blair." Toronto Police Service (July 2014), <https://www.tps.ca/services/resource-centre/police-encounters-with-people-in-crisis/>.

<sup>104</sup> According to the Ontario Court of Appeal, which considered the appeal of Constable Forcillo's attempted murder conviction for shooting Mr. Yatim, Mr. Yatim was eighteen years old, had consumed ecstasy, and had been contemplating suicide. Late at night on a Toronto streetcar, he brandished a switchblade knife, exposed himself to passengers, and made a slashing motion towards a female passenger. Constable James Forcillo, one of the officers who responded to the incident, stood outside the streetcar door and told Mr. Yatim to drop the knife. Mr. Yatim moved toward the streetcar stairs. Constable Forcillo shot Mr. Yatim three times. Mr. Yatim fell to the ground, and Constable Forcillo shot at him another six times. Constable Forcillo was acquitted of murder but convicted of attempted murder (relating to the second volley of shots). *R v Forcillo*, 2018 ONCA 402 (CanLII), <https://canlii.ca/t/hrqkb>, leave to appeal dismissed, 2018 CanLII 116610 (SCC), <https://canlii.ca/t/hwg2b>. The Office of the Independent Police Review Director (OIPRD) is also conducting a review of the use of force by TPS members during encounters with people in crisis in response to Mr. Yatim's death, which commenced after Mr. Iacobucci's review. "Police Interactions with People in Crisis and Use of Force: OIPRD Systemic Review Interim Report." Office of the Independent Police Review Director, Ontario (March 2017), <https://www.oiprd.on.ca/wp-content/uploads/Police-Interactions-with-People-in-Crisis-and-Use-of-Force-Systemic-Review-Report-March-2017-Small.pdf>.

provincial and federal governments because, simply put, they are part of the problem and need to be involved in the solution.”<sup>105</sup>

Mr. Iacobucci emphasized the difficult position in which police officers find themselves during encounters with people in crisis. He said,

Frontline police officers have one of the most challenging jobs that society has to offer. They are demanded to perform difficult and unpleasant tasks that most citizens are unwilling or unable to carry out themselves. These tasks often involve risking their lives in order to control and apprehend people who are violent or otherwise dangerous— including not only violent criminals but also people in various forms of crisis who are not criminals but who may, knowingly or not, be a threat to themselves or others. The job of the frontline officer is one of considerable risk. Officers regularly have to balance their duty to confront danger (with often very limited information about the nature of the danger) against the personal risks to themselves—a very challenging task that few others in society are required to undertake in the same way or to the same extent...

Police operate within an organization that places a high value on personal toughness and self-reliance. Yet frontline police are exposed to scenes of despair, pain, tragedy, and horror as a regular part of their job. It is virtually inevitable that such exposure affects their own mental health—causing at the very least some degree of emotional detachment from the subjects with whom they deal and, not infrequently, more serious mental health issues. The importance of the mental health of the police themselves should not be underestimated in analyzing how to ensure better outcomes of encounters with people in crisis.<sup>106</sup>

The reality that frontline officers are frequently in dangerous situations may also lead them to resort to force more quickly than they otherwise might: “It is understandable that officers may feel impelled to try to control dangerous situations quickly. Fear, particularly if combined with less-than-ideal mental health of the officer, makes empathy and patience more difficult.”<sup>107</sup>

Mr. Iacobucci identified the command structure of police organizations as counterproductive during these encounters:

Another feature of the TPS, which is similar to other police organizations, is the Service’s paramilitary command structure and its pervasive focus on legal compliance. Frontline officers become accustomed to dealing with certain types of dangerous situations through a system of command, physical confrontation (if necessary), enforced compliance, and negative sanctions for non-compliance. While this compliance-based approach can be very beneficial in many contexts, it can be counterproductive when dealing with a person in crisis, who may not understand or be able to respond to commands. This is not to say that all police interactions with members of the public are premised on a compliance-based approach—far from it. Many, if not most, encounters between the police and the public are cooperative and respectful. But in dangerous situations, there is a tendency and, in some contexts, a real or perceived requirement for police to use a compliance-based approach. This can be problematic when a more conciliatory approach, focused on de-escalation, delay, and containment, is preferable to confrontation.<sup>108</sup>

A number of stakeholders raised concerns about the oversight role played by the Toronto Police Services Board. Mr. Iacobucci declined to make any specific recommendations about the Board,

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<sup>105</sup> “Police Encounters with People in Crisis,” p. 8.

<sup>106</sup> “Police Encounters with People in Crisis,” p. 50.

<sup>107</sup> “Police Encounters with People in Crisis,” p. 50.

<sup>108</sup> “Police Encounters with People in Crisis,” p. 50.

as it was outside of his mandate, but commented that, “It is clear that the Board and the Chief of Police need to work well together as partners, and that the Board itself needs to function efficiently and effectively in order to provide necessary civilian oversight.”<sup>109</sup>

Mr. Iacobucci noted the numerous initiatives the TPS had engaged in to address the issue of police response to people in crisis and police use of force in those and other contexts. These included staff positions focused on mental health and policing, committees on use of force and mental health, officer training on crisis resolution, and mobile crisis intervention teams. In addition, an access line operated by the TPS, the Community Referral Police Access Line, provides assistance to officers interacting with people who may be “emotionally disturbed,” who have not been apprehended under the Mental Health Act, and who are at risk of involvement with the criminal justice system. The line can connect officers with community mental health organizations, including those operating short-term residential programs and those participating in the Mental Health and Justice Prevention Program.<sup>110</sup>

Mr. Iacobucci also discussed a tool created by the Vancouver Police Department in collaboration with Vancouver Coastal Health, known as the “Dashboard.” The Dashboard is a database containing mental health and police information, which officers in the field can access to obtain information when dealing with a person in crisis. This information includes the location of all mental health resources in the city and information on wait times at emergency psychiatric facilities. The database also includes information on repeat users of emergency mental health services, including recent Mental Health Apprehensions and recent violent or substance-abuse-related offences, and whether officers believe any recent call involved mental health issues. Mr. Iacobucci noted the importance of ensuring privacy safeguards and respecting physician–patient confidentiality when sharing mental health information with the police.

Mr. Iacobucci reviewed the policies and procedures governing TPS responses to people in crisis and the roles of 911 call takers, first responders, supervisors, and others. Among these procedures is a requirement that Emergency Response Teams be notified by Communications Services of all calls involving people in crisis. ERT teams had rarely been involved in a fatal response to a person in crisis, and Mr. Iacobucci concluded that the ERT is “a model of successful de-escalation, containment and non-violent resolution of incidents” that could teach other officers how best to respond to people in crisis.

One chapter of the report focused on Toronto’s Mobile Crisis Intervention Team (MCIT). Specially trained uniformed officers from TPS are teamed with a mental health nurse from a Toronto hospital and provide mobile responses to people in crisis. This includes assessment and support, connection to appropriate community services, transporting people in crisis to a hospital for voluntary treatment, de-escalation and prevention of injury to police and the person in crisis, apprehension under the Mental Health Act where appropriate, and diverting justice system involvement. The cost is shared by TPS and the local health authority. Referrals to MCIT are made following 911 calls or come from officers in the field. Mr. Iacobucci praised the MCIT model as its staff can access both police and health records to inform them as to the appropriate response; the mental health nurses are skilled in interacting with people in crisis; and the specially trained MCIT officers can reduce the stigma of mental illness within the TPS. However, MCITs

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<sup>109</sup> “Police Encounters with People in Crisis,” p. 67.

<sup>110</sup> See the webpage of the Canadian Mental Health Association “Mental Health and Justice (MHJ) Crisis Prevention Services” (posted 21 August 2012), <https://toronto.cmha.ca/programs-services/mental-health-and-justice-mhj-crisis-prevention-services/>.

are not deployed to respond to people in crisis as often as they should be, due in part to lack of officer familiarity with the function of MCIT and the very low number of available MCIT units.

Mr. Iacobucci also reviewed the various models for emergency mental health response available in other jurisdictions, including first responses by mental health professionals without police and first response by specially trained police officers without mental health professionals.

Mr. Iacobucci addressed information-sharing between police and mental health service providers, noting that it is a sensitive issue:

It would be useful if TPS officers were able to receive mental healthcare information in situations involving a person in crisis, with the caveat that strict limitations need to be placed on the use and subsequent disclosure of that information in order to respect patient privacy. Some measures for information-sharing may require legislative or regulatory change. This is an area of cooperation that requires all interested groups, including policing, civil liberties, mental healthcare, and people who have experienced mental illness, to come together to find a way forward. Their common goal should be to give the police access to all information that could enable them to help people in crisis while respecting individuals' privacy by limiting other uses of that information.

As discussed above, it is clear that in certain circumstances, many of which arise in serving people in crisis, the Toronto Police Service carries out a role that is integral to mental healthcare services, and, in effect, police officers become part of the care pathway for people in crisis.

...[O]ne of the tensions in the MCIT [Mobile Crisis Intervention Team] model is that there are two separate sources of information: the police database and the healthcare system. A point of uncertainty that warrants resolution is whether people in crisis may benefit if MCIT officers and nurses are permitted to share information with each other that they access from their respective positions within the police and healthcare systems. In practice, it may be impracticable not to share this information if the MCIT unit is to function efficiently and in the best interests of the person in crisis.<sup>111</sup>

However, Mr. Iacobucci noted the serious adverse consequences that can result from overbroad sharing of mental health information, citing difficulties some people have crossing the border due to the accessibility of police database information by members of the Canadian Border Services Agency.

## **Police Culture**

Although examining police culture was not a formal part of Mr. Iacobucci's mandate, he found that the issue was sufficiently important to his review to justify a separate chapter. He noted that a number of stakeholders had noted the adage that "culture eats training" and that while formal training of officers is relatively short, the culture of policing surrounds officers at all times. He said,

Culture must align with the training in order for the training to be effective over the longer term. The pressure to conform to the prevailing culture is significant, and the lessons of training will be ineffective if they conflict with the practice in the field and the expectations of fellow officers and supervisors.<sup>112</sup>

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<sup>111</sup> "Police Encounters with People in Crisis," p. 107.

<sup>112</sup> "Police Encounters with People in Crisis," p. 117.

Mr. Iacobucci enumerated areas in which the culture of the TPS is positive and also identified areas of improvement. Among the areas for improvement were beliefs among some officers that deaths of people in crisis are inevitable, that police officers should not be expected to act as social workers, and that there will always be bad actors among the force. Some members also expressed the view that the safety of a police officer is more important than the safety of a person in crisis. That view was also reflected in some training materials. Mr. Iacobucci disagreed, stating that the lives of officers and people in crisis are equally important. Although officers must protect themselves in order to be able to protect the public, they also have a duty to protect the person in crisis. Mr. Iacobucci also concluded that because the TPS persistently faces public criticism, and much of that criticism is ill informed or unfair, there is a “generalized assumption that criticism of the TPS by people outside of the Service is unhelpful, and that only members of the TPS truly understand the requirements of policing.”<sup>113</sup> He described this assumption as unhelpful. At the same time, junior members of the TPS are reticent to speak out about concerns they have, fearing that it will be seen as insubordination. Mr. Iacobucci identified this reticence as a product of the paramilitary command structure of the TPS and noted that it stifles innovation, self-examination, and self-criticism.

Mr. Iacobucci found that it was difficult to discipline or dismiss Toronto police officers under their governing legislative framework, because of a desire to protect the independence of police officers as public office holders. He concluded that because the TPS was therefore limited in its ability to shape or correct the conduct of its officers, it must focus on hiring people who demonstrate the traits it wants its officers to have, such as empathy, compassion, or healthy attitudes toward people with mental illness. He recommended increased participation of psychologists in the frontline officer candidate screening process, as there are for the screening of Emergency Response Team candidates. Mr. Iacobucci also referred to research showing that there are significant benefits to hiring officers who have post-secondary education, including a reduction in the use of force and a greater understanding of the ethical issues involved in policing.

## **Training**

In response to the recommendations of other reviews and inquiries, the TPS had made significant changes to the content and delivery of its training programs for recruits and for staff on responding to people in crisis and on the use of force. Mr. Iacobucci reviewed this training and found that it was reasonably well developed. He noted the significant training that is required for officers to understand and properly respond to people in crisis.

## **Supervision**

The review considered the structure and efficacy of supervision in ensuring the appropriate response to people in crisis. Mr. Iacobucci noted the importance of supervision:

An effective system of positive and negative reinforcement—for officers and for supervisors—is an essential element of creating a culture that enhances, rather than “eats,” training. As one stakeholder put it, supervisors need to lead, not just supervise.<sup>114</sup>

The TPS uses a “coach officer” program, whereby officers who have completed a coach training course train and mentor new recruits in the field. The coach officer training program focuses on ethical and professional behaviour, integrity, fairness, and personal bias. These coaches must

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<sup>113</sup> “Police Encounters with People in Crisis,” pp. 123–24.

<sup>114</sup> “Police Encounters with People in Crisis,” p. 158.

monitor and report on the recruits' progress and skills. Mr. Iacobucci noted the critical influence that coach officers can have. However, if not properly screened or trained, they can also perpetuate negative stereotypes and, as one commentator said, can "undo six months of training in half an hour."<sup>115</sup> There is no formal mechanism to evaluate this program.

Given the legislative constraints on disciplining and discharging officers for misconduct, performance reviews have an important role to play in identifying problems with officers' compliance with expectations. However, Mr. Iacobucci found that the annual performance reviews are not always constructive or meaningful. He suggested that these reviews should identify the officers' skills or limitations in de-escalation and communication, and these skills should be recognized and considered when determining promotions to higher ranks and specialty units. He also identified the value of debriefing with officers following incidents involving people in crisis but noted the problems involved with maintaining the confidentiality of these debriefings.

Mr. Iacobucci emphasized that senior management must commit to protecting officers who report misconduct by their colleagues. This would include providing officers with training and resources on how to report misconduct committed by other officers and holding supervisors responsible when they fail to respond appropriately to misconduct.

Mr. Iacobucci reviewed a number of reports of internal TPS investigations into the use of force. He found that these reports focused on whether the use of force in the particular incident complied with the minimum legal standards. They did not consider whether there were alternatives to the use of force or whether it would have been possible to use less force. They also failed to consider whether all policies and procedures were followed, including supervision, communication, and the chain of command. Mr. Iacobucci stated that in order to teach officers that they must avoid death and injury, particularly during calls relating to people in crisis, some disciplinary measures may have to be taken where officers fail to attempt de-escalation, and these reports should identify gaps in policies and training.

The review discussed innovative performance monitoring databases in other jurisdictions, including Las Vegas and Los Angeles, which focus on early intervention rather than discipline. Information about officers' arrests, crime reports, complaints, use of force, weapon qualification, and other issues is collected into a "dashboard," which is then reviewed by supervisors. Supervisors can identify red flags through comparison with the officers' peers or through system-generated alerts when conduct has been previously associated with complaints or workplace safety problems. They can then intervene to provide support or training to the officer.

### **Officer Wellness**

Mr. Iacobucci also examined the role of officer mental health, noting that an officer must be able to manage their own stress in order to respond calmly and with empathy to a person in crisis. He noted that exposure to trauma is inherent in policing:

While estimates for the prevalence of mental illness in Canada vary as a result of divergences in definitions and research methodology, it is indisputable that mental health issues are common in Canadian society. Police officers are no more immune to such issues than others. Rather, because they must deal on a day-to-day basis with some of the most saddening features of human nature, it appears that police are more likely than the average person to experience mental health difficulties...

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<sup>115</sup> "Police Encounters with People in Crisis," p. 164, quoting an unnamed commentator.

... One recent study found that police officers in Canada “are exposed to a fairly unique set of stressors and face a different set of challenges at work than most employees,” challenges which include the pressure to take on work that falls outside their mandate, multiple competing and constantly changing demands, understaffing, the complexity of navigating the criminal justice system, and managing the expectations of the public. Moreover, this study does not touch on another challenge unique to policing: the inherent dangers of police work.

According to several studies, mostly from the US, officers commonly suffer from significant psychological issues. One study found that approximately one third of police officers who are exposed to work-related traumatic incidents develop significant post-traumatic symptoms and other complex psychological issues that can interfere with their duties and responsibilities as a police officer. Another study found that at least 25 percent of police officers meet the standard clinical criteria for alcohol abuse.

Officers and their domestic partners consistently report that the policing occupation is a significant source of stress in their relationship, impacting their lives at home. Post-traumatic stress disorder and elevated rates of alcohol abuse may cause increased aggression. Police families have been shown to have higher rates of domestic violence than the wider civilian population.

Officers can also have difficulty asking for help. Fear of stigmatization, negative job consequences, and perceptions of personal weakness and failure all impede police officers from seeking help that they may need. As a result of the police working environment, there is evidence from a US study that the rate of police suicide is approximately 1.5 times that of the general population.<sup>116</sup>

The TPS wellness program provided in-house psychological services for TPS members. Officers engaged in specific duties that could be expected to affect their mental health, such as child exploitation investigators, ERT gun team members, undercover drug squad members and 911 call takers, were required to meet at least annually with a TPS psychologist. The psychologists were also available to meet with any other officer on a voluntary basis. Mr. Iacobucci learned that mental illness was still somewhat stigmatized within the TPS, and seeking psychological services was considered a sign of weakness. The mandatory meetings for high-risk officers removed that stigma and cultural resistance. Mr. Iacobucci suggested that other TPS officers, particularly frontline officers within the primary response units who have the most frequent contact with people in crisis, would benefit from mandatory meetings with psychologists. He referred to a “compelling body of opinion suggesting that [junior] officers’ mental health needs should be monitored and treated early, to ensure that mental health issues do not grow into significant problems that can affect the individual officer and the Service as a whole.”<sup>117</sup> Supervisors would also benefit from mandatory psychological meetings.

Mr. Iacobucci noted that the TPS did not have a comprehensive psychological health and safety management system or a comprehensive psychological wellness statement for its officers. He suggested that the TPS adopt the national workplace mental health standard established by the Mental Health Commission of Canada,<sup>118</sup> adapted for police officers.

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<sup>116</sup> “Police Encounters with People in Crisis,” pp. 180–81.

<sup>117</sup> “Police Encounters with People in Crisis,” p. 184.

<sup>118</sup> The Mental Health Commission of Canada website (<https://mentalhealthcommission.ca/national-standard/>) describes this Standard as “a set of voluntary guidelines, tools and resources intended to guide organizations in promoting mental health and preventing psychological harm at work.”

The TPS required members who were involved in traumatic critical incidents to engage in several stages of debriefing. The first debrief was a mandatory 30-minute informal “defusing session” led by specially trained peer support volunteers known as the Critical Incident Response Team (CIRT). TPS psychologists may also attend. A longer and more formal debriefing session focused on the officer’s reaction to the traumatic incident took place a few days later with a TPS in-house psychologist and CIRT members. The facts of the incident itself were not discussed at this debriefing, given that the incidents might be the subject of a Special Investigations Unit investigation or criminal proceeding. Supervisors were also required to determine what additional support the officer might need. Supervisors were otherwise not required to monitor the mental health of members or assist them in accessing treatment, other than to ensure they were fit for duty (a low standard). Mr. Iacobucci suggested that supervisors should pay attention to the mental wellbeing of their team members and promote mental health on their team:

Because supervisory officers are not specifically tasked with monitoring officers’ overall mental health except in the case of fitness for duty concerns, the degree to which early intervention is undertaken in practice is largely dependent on the attitude and approach of individual unit commanders and other supervisory officers, as well as coach officers. The Review was advised by several individuals that, as a general matter, the Service’s culture does not emphasize ongoing monitoring, correction, learning, and counselling with respect to mental health issues. As a result, problems are usually addressed only when they become significant or worse.

Part of the issue is that officers are concerned that they will suffer adverse professional consequences if they identify a need for help or if supervisors intervene to suggest help. It is important to an effective mental health culture of continuous treatment and learning to ensure that members of the Service are encouraged to view mental healthcare as helpful and non-threatening.<sup>119</sup>

## Use of Force

A chapter of the report focused on the Ontario and TPS framework for the use of force in the context of encounters with people in crisis.

Mr. Iacobucci set out the legal and regulatory framework for the use of force by police officers, including the criminal law.<sup>120</sup> The provincial requirements relating to the use of force are set out

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<sup>119</sup> “Police Encounters with People in Crisis,” p. 189.

<sup>120</sup> The report summarizes the criminal and civil liability of officers who use force as follows (p. 201):

The Criminal Code limits the acceptable level of force used by police officers acting under legal authority. Police officers may, acting on reasonable grounds, use force to prevent the commission of certain offences, to prevent a breach of peace, to suppress a riot, and “to do anything in the administration or enforcement of the law.” The force used must be proportionate, or reasonably necessary, in the circumstances. The Supreme Court of Canada has explained that police actions should not be judged against a standard of perfection, but in light of the exigent circumstances of dangerous and demanding work and the obligation to react quickly to emergencies.

An officer may not use force that can cause grievous bodily harm or death unless he or she believes on reasonable grounds that it is necessary to preserve life, to prevent the infliction of grievous bodily harm on anyone, or to prevent escape of a person to be arrested if the officer believes that the person poses a risk to the life or safety of anyone and cannot be subdued in a less violent manner.

Specifically, the reasonableness of the grounds for an officer’s use of force should be judged both objectively (from the perspective of an average police officer) and subjectively (from the perspective of the particular officer who used force). The level of force must be “reasonable in light of circumstances faced by the police officer.”

Police officers may also be held civilly liable for injuring or killing members of the public in the course of their duties. Under the law of negligence, for example, police officers owe a duty of care to members of the public when carrying out their duties. Police must act reasonably and within their statutory powers, according to the circumstances of the situation. This standard contemplates that officers must exercise discretion in their duties, and will not be held liable for conduct that falls within the range of reasonableness.

in a regulation of the Ontario Police Services Act. Under this regulation, a police officer who has not completed the prescribed training and annual requalification training on the use of force is not permitted to use force against another person. Officers must also complete a Use of Force Report after any incident in which they use physical force requiring medical attention, draw a handgun in the presence of the public, discharge or point a firearm, or use another weapon on another person. Officers may only draw, point, or discharge a firearm when they have reasonable grounds to believe such action is necessary to protect against the loss of life or serious bodily harm. They are also prohibited from firing warning shots or firing at a moving vehicle unless the occupants pose an immediate threat of death or grievous bodily harm. Police services and their boards must adopt policies and procedures incorporating these provincial use of force standards. The province maintains a Policing Standards Manual containing advisory guidelines for the implementation of these policies and procedures, which contains sample board policies and police services guidelines. Mr. Iacobucci explained the training expectations as follows:

The Policing Standards Manual recommends that annual handgun requalification training include the following minimum components:

- a. 1 hour classroom training on use-of-force legislation and reporting requirements (among other topics);
- b. 1.5 hours proficiency training; and
- c. 1.5 hours judgment development training designed to develop decision-making skills in stressful situations.

This training may include role-playing and simulations, and it should involve debriefing after practical exercises on threat perceptions, communication skills, tactics used, less-lethal force options, and justification for amount of force used, among other topics.

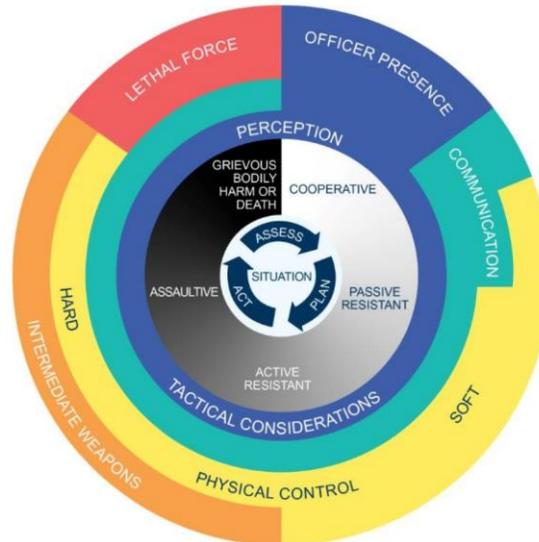
The Manual dictates that use-of-force reports should be used only to identify individual and group training requirements or organizational policy requirements. The guidelines recommend that use-of-force policies require that the information collected in use-of-force reports not be placed in an officer's personnel file.<sup>121</sup>

The province's guidelines provide that training on the use of force should be conducted with reference to the province's Use of Force Model, also known as the "Use of Force Wheel." That model, which is based on a national Use of Force Model, is a graphic that represents the decision-making used by officers to identify the appropriate tactic to control a potentially dangerous situation.

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Courts must further consider the essential function performed by police officers and the urgent contexts in which they must make decisions and take actions.

<sup>121</sup> "Police Encounters with People in Crisis," p. 196.



**Figure 1: Ontario Use of Force Model**

Source: Police Encounters with People in Crisis report, p. 197

According to the report, this model is based on six principles:

- a. the primary responsibility of a police officer is to preserve and protect life;
- b. the primary objective of any use of force is to ensure public safety;
- c. police safety is essential to public safety;
- d. the Use of Force Model does not replace or augment the law;
- e. the Model was constructed in consideration of the law; and
- f. the Model does not dictate policy to any agency.<sup>122</sup>

According to this model, an officer will continually assess, plan, and act. They will assess the situation according to the subject's strength, access to weapons, intoxication, and emotional state; whether the officer needs to act immediately or has time to create distance between the subject and other people; and whether the subject is engaging in behaviour that can indicate a potential attack on the officer, such as ignoring the officer, refusing to comply, ceasing all movement, hiding, or adopting an aggressive stance. Several stakeholders took the position that the behaviour that is identified in the model as indicating a potential threat includes virtually all conduct other than immediate compliance with police directions, and this formulation can lead officers to interpret signs of mental health crisis as signs of imminent attack. Mr. Iacobucci agreed that it appears that "symptoms of crisis, and even displays of fear, may be perceived by an officer trained in the Use of Force Model as aggressive behaviours warranting an escalated police response."<sup>123</sup>

Mr. Iacobucci noted that materials accompanying the Use of Force model that set out the options available to an officer in a potentially dangerous situation include only one example of communication: stating the "police challenge": "Police. Don't move." Dialogue and reassurance, which could de-escalate situations involving people in crisis, are not suggested. He stated that officers should be trained to attempt to speak calmly with a person in crisis as part of their assessment of both the person's likely conduct and the best options for diffusing the danger. He

<sup>122</sup> "Police Encounters with People in Crisis," p. 197.

<sup>123</sup> "Police Encounters with People in Crisis," p. 199.

concluded that “there is surprisingly little focus on the need to attempt various methods of communication before using physical force or a weapon on a person.”<sup>124</sup> The Use of Force graphic is also not intuitive or clear, so it is not a particularly helpful reference or training tool for officers.

Under the TPS Use of Force Procedure, officers must use only that force which is reasonably necessary to bring an incident under control effectively and safely. The Procedure notes that the Use of Force model is an aid and does not justify or prescribe any specific response. The Procedure authorizes the use of force that is intended or likely to cause death or grievous bodily harm where the officer reasonably believes that the “person to be arrested takes flight to avoid arrest; the force is necessary for the purpose of protecting the peace officer, the person lawfully assisting the peace officer or any other person from imminent or future death or grievous bodily harm; [and] the flight cannot be prevented by reasonable means in a less violent manner.” Officers must contain the scene and disengage when tactically appropriate.

When an officer discharges a firearm, they must notify their supervisor, who must complete a Firearm Discharge Report; the officer-in-charge and the duty inspector must also be notified. A Firearm Discharge Investigator from the TPS Professional Standards unit will then investigate.

Supervisors review the Use of Force reports, and where they identify the need for additional training, they submit the reports to trainers at the Toronto Police College. Use of Force Reports may not be recorded in an officer’s personnel file or be considered during promotional or job assignment reviews. Firearms Discharge Reports may lead to recommendations on policy and training from the Professional Standards Unit, which in turn are reviewed by the TPS Use of Force Review Committee. That committee includes members from the Emergency Task Force, Toronto Police College, Professional Standards Investigative Unit, and the Public Safety and Emergency Management Unit. The Committee also reviews other use of force incidents and advises the TPS Senior Management Team of any resulting suggestions regarding TPS training, practices, and governance to the TPS Senior Management Team. However, there are no formal reports or minutes of those proceedings.

Mr. Iacobucci reviewed other models governing the use of force by police officers. The International Association of Chiefs of Police (IACP) Model Policy on the use of force identifies frontline supervision as the most important aspect of use of force regulation. The United Nations Basic Principles on the Use of Force and Firearms by Law Enforcement officials recommend initial screening and periodic review to ensure officers have appropriate moral, physical, and psychological attributes. The UN also requires that in any case of unauthorized use of force, both the officer and any supervisor who ought to have known of the conduct and did not take measures to prevent it must be disciplined and held accountable. Officers are also required to report violations of procedures by their colleagues. Mr. Iacobucci noted that the UN standards place more emphasis on the need to avoid using lethal force wherever possible than do the Ontario Use of Force model or the TPS procedure.

Much of this chapter was focused on options to avoid the use of force during encounters with people in crisis, which are not detailed here. Another chapter focused on equipment used in encounters with people in crisis, including conducted energy weapons (Tasers), batons, and body cameras. That material is not summarized here.

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<sup>124</sup> “Police Encounters with People in Crisis,” p. 200.

## Implementation of Recommendations

Mr. Iacobucci focused a chapter of his report on the implementation of his recommendations. He said,

While the creation of this Review was itself a watershed moment for the TPS, the greatest challenge for the TPS will be implementation. For this Review to be truly meaningful, implementation is essential. Too often reports such as this one are prepared at great effort and expense, only to lay dormant, waiting in vain for someone to put the recommendations into practice. It is for this reason that I have prepared this last set of recommendations—arguably the most important recommendations—dealing with implementation.<sup>125</sup>

He recommended that the TPS consider eight factors when implementing the recommendations:

- Stakeholder input, to ensure that the implementation of the recommendations is “grounded in the reality of people’s experience.”<sup>126</sup> Involving stakeholders in implementation will also promote their acceptance of the process as legitimate.
- Transparency and accountability, to ensure that the public understands the priority given to some recommendations over others, both in terms of timing and resource allocations.
- Respect for the role of the Chief of Police, recognizing that the Police Services Act gives the Chief ultimate responsibility for the administration and operation of the TPS.
- Respect for the role of the Toronto Police Services Board. Although none of the recommendations directly involve the TPSB, it would play significant part in overseeing the implementation of the recommendations, given its oversight function.
- Leadership: moral leadership to set expectations for reform, organizational leadership to carry out the implementation of the recommendations, and institutional leadership, with the TPS taking on a leadership role with other organizations to achieve some of the recommendations.
- Collaborative relationships with hospitals, people with lived experience with mental illness, and academic institutions, which will be essential for the full and effective implementation of the recommendations.
- Resource sensitivity, given the scarcity of resources and the reality that despite Mr. Iacobucci’s efforts to make pragmatic, achievable recommendations, some prioritizing and adapting of the recommendations may have to be made. At the same time, there are potential cost savings associated with many of the recommendations. The report emphasized the costs involved in the killing of a person in crisis by police:

Budgetary constraints cannot be treated as more important than lives. At the same time, there are financial costs that arise from the use of lethal force that should not be ignored. Our society spends huge amounts on SIU investigations, inquests, criminal proceedings, civil proceedings, mental health care costs, and other expenses associated with fatal shootings. Those who make decisions about funding for police initiatives such as those recommended in this Report must consider this side of the financial coin.<sup>127</sup>

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<sup>125</sup> “Police Encounters with People in Crisis,” p. 268.

<sup>126</sup> “Police Encounters with People in Crisis,” p. 269.

<sup>127</sup> “Police Encounters with People in Crisis,” p. 271.

- Ongoing review, to assess the degree to which the recommendations have been implemented and successful and to make further recommendations for improvement.

### **The Response by the TPS to the Independent Review**

In 2018, the Toronto Police Service published a status update on the implementation of Mr. Iacobucci's recommendations.<sup>128</sup> This status report set out the recommendations, along with commentary on the TPS position as to whether the recommendation should be implemented or should be implemented in another form, as well as progress to date. According to this document, 94% of the recommendations had been implemented.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. The TPS create a comprehensive police and mental health oversight body in the form of a standing interdisciplinary committee that includes membership from the TPS, the sixteen designated psychiatric facilities, the three Local Health Integration Networks covering Toronto, Emergency Medical Services, and community mental health organizations to address relevant coordination issues, including:
  - a. Sharing Healthcare Information: developing a protocol to allow the TPS access to an individual's mental health information in circumstances that would provide for a more effective response to a person in crisis. This protocol must respect privacy laws and physician–patient confidentiality and should address:
    - i. whether, in consultation with the Government of Ontario, the concept of the “circle of care” for information-sharing can be expanded to include the police in circumstances beneficial to an individual's healthcare interests;
    - ii. how healthcare, treatment, and planning information with respect to people with repeated crisis interactions with the police can be shared with the TPS while respecting all relevant privacy and physician–patient confidentiality concerns; and
    - iii. more specifically, how healthcare information shared with the TPS can be segregated from existing police databases and therefore prevented from subsequently being passed on to other law enforcement, security and border services agencies. Healthcare information should continue to be treated as such and not as police information.
  - b. Voluntary Registry: the creation of a voluntary registry for vulnerable persons, complementing the protocol recommended in (a), which would provide permission to healthcare professionals to share healthcare information with the police, to be accessed only by emergency responders in the event of a crisis situation and subject to due consideration to privacy rights;
  - c. Mutual Training and Education: how psychiatric facilities, community mental health organizations, and the TPS can benefit from mutual training and education;
  - d. Informing Policymakers: informing policymakers at all levels of government, in the aim of making the mental health system more comprehensive;

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<sup>128</sup> Toronto Police Service, “Iacobucci Review Implementation Status”, Response to Iacobucci Report” (2018) online at <https://www.tps.ca/services/resource-centre/iacobucci-review-implementation-status/> (last accessed on 24 August 2022).

- e. **Advocacy:** advocating more comprehensive and better funded community supports for people with mental illness. This would be a multi-party initiative led by the mental health sector. It should include, among other things, planning for community treatment supports upon discharge from the hospital and the creation of more “safe beds” in shelters for people in crisis, to be used when they do not meet the criteria for apprehension under the Mental Health Act but need assistance to stabilize their crisis [...]
2. The TPS more proactively and comprehensively educate officers on available mental health resources, through means that include:
  - a. **Mental Health Speakers:** inviting members of all types of mental health organizations to speak to officers at the divisions;
  - b. **Technological Access to Mental Healthcare Resources:** considering the use of technological means, similar to Vancouver’s “Dashboard” system, to efficiently communicate to officers a comprehensive up-to-date list or map of available mental health resources of all types in their area. Such an easily accessible reference tool should aggregate information on all community supports, in addition to major psychiatric facilities; and
  - c. **Point of Contact:** working with mental health organizations to identify key resource people or liaisons, so that every TPS officer has a contact in the mental health system that they feel comfortable contacting for advice and who is able to knowledgeably give that advice.
3. The TPS amend Procedure 06-04 “Emotionally Disturbed Persons” to provide for the mandatory notification of MCIT units for every call involving a person in crisis.
4. The TPS change mandatory application qualifications for new constables to require the completion of a Mental Health First Aid course, in order to ensure familiarity and some skill with this core aspect of police work.
5. The TPS give preference or significant weight to applicants who have:
  - a. **Community Service:** engaged in significant community service, to demonstrate community-mindedness and the adoption of a community service mentality. Community service with exposure to people in crisis should be valued;
  - b. **Mental Health Involvement:** past involvement related to the mental health community, be it direct personal experience with a family member, work in a hospital, community service, or other contributions; and
  - c. **Higher Education:** completed a post-secondary university degree or substantially equivalent education.
6. The TPS consider whether to recruit actively from certain specific educational programs that teach skills that enable a compassionate response to people in crisis, such as nursing, social work, and programs relating to mental illness.
7. The TPS direct its Employment Unit to hire classes of new constables that on the whole demonstrate diversity of educational background, specialization, skills, and life experience, in addition to other metrics of diversity.
8. The TPS instruct psychologists, in carrying out their screening function for new constable selection, to assess for positive traits in addition to assessing for the absence of mental illness or undesirable personality traits. In this aim, the TPS, in consultation with the

psychologists, should identify a specific set of positive traits it wishes to have for new recruits and should instruct the psychologists to screen-in for those traits.

9. The TPS include the psychologists in the decision-making process for new constable selection, in a manner similar to their involvement in selecting officers for the TPS Emergency Task Force.
10. The TPS compile data to allow the Service to evaluate the effectiveness of the psychological screening tests that it has used in selecting recruits. Relevant data may include data that show what test results correlate with officers who have satisfactory and unsatisfactory interactions with people in crisis.
11. The TPS strike a working group that includes participation from the TPS Psychological Services unit to comprehensively consider the role of Psychological Services within the TPS, including:
  - a. More Information: whether the current process for psychological screening of new constables is effective and whether it could be improved, including whether TPS psychologists should be given more information about candidates to assist them in interpreting their test results;
  - b. Involvement of Psychologists in other Promotion Decisions: whether Psychological Services should be authorized to conduct evaluations of and otherwise be involved in discussions regarding the selection processes for officer promotions within the Service and the selection of coach officers;
  - c. MCIT: whether the TPS psychologists should be involved in the selection and training of officers and nurses for the MCIT. More broadly, the TPS should consider how to facilitate a close and ongoing relationship between the psychologists and the MCIT in order to enable collaboration and information sharing between the Service's two units with a primary focus on mental illness;
  - d. Organizational Structure: whether the TPS should amend its organizational structure so that Psychological Services reports directly or on a dotted-line basis to a Deputy Chief, in order to give greater recognition to the operational role that they play; and
  - e. Expanding Psychological Services: how Psychological Services should be expanded to accommodate the officer selection duties and TPS members' wellness needs, as described in this Report.
12. The TPS place more emphasis in its recruit training curricula on such areas as:
  - a. Containment: considering and implementing techniques for containing crisis situations whenever possible in order to slow down the course of events and permit the involvement of specialized teams such as ETF or MCIT as appropriate;
  - b. Communication and De-escalation: highlighting communication and de-escalation as the most important and commonly used skills of the police officer, as well as the need to adjust communication styles when a person does not understand or cannot comply with instructions;
  - c. Subject Safety: recognizing the value of the life of a person in crisis and the importance of protecting the subject's safety as well as that of the officer and other members of the public;
  - d. Use of Force: making more clear that the Use of Force Model is a code of conduct that carries

- i. a goal of not using lethal force; and
    - ii. a philosophy of using as little non-lethal force as possible;
  - and that the Model is not meant to be used as a justification for the use of any force;
  - e. Firearm Avoidance: implementing dynamic scenario training in which a recruit does not draw a firearm, as a means of emphasizing the non-lethal means of stabilizing a situation and reducing the potential for over-reliance on lethal force;
  - f. Fear: including discussions of officers' fear responses during debriefings of practical scenarios that required de-escalation and communication techniques to defuse a crisis situation;
  - g. Stigma: addressing and debunking stereotypes and stigmas concerning mental health. For example, the TPC could build on its use of video presentations involving people with mental health issues by adding interviews with family members of people who have encountered police during crisis situations and police officers who were present during a crisis call that resulted or could have resulted in serious injury or death;
  - h. Experience and Feedback: incorporating mental health and crisis situations into a larger number of practical scenarios to provide recruits with more exposure to and feedback on techniques for resolving such situations; and
  - i. Culture: laying the foundation for the culture the TPS expects its officers to promote and embody, and preparing recruits to resist the aspects of the existing culture that do not further TPS goals and values with respect to interactions with people in crisis.
13. The TPS consider whether officers would benefit from additional tools to assist them in responding to crisis calls, such as a quick-reference checklist for dealing with people in crisis that reminds officers to consider: whether the person is demonstrating signs of fear versus intentional aggression; whether medical, background, and family contact information is available; whether alternative communication techniques are available when initial attempts at de-escalation are unsuccessful; whether containment of the person and the scene is a viable option; and whether discretion should be used in determining whether to apprehend, arrest, divert, or release the person in crisis.
14. The TPS consider whether the twenty-week recruit training period should be extended to allow sufficient time to teach all topics and skills required for the critically important work of a police officer.
15. The TPS consider requiring officers to re-qualify annually or otherwise in the areas of crisis communication and negotiation, de-escalation, and containment measures.
16. The TPS consider how decentralized training can be expanded and improved to focus on such issues as:
- a. Platoon training: increasing opportunities for officers to engage in traditional and online mental health programming within their platoons;
  - b. Exposure: providing officers with in-service learning exercises that involve direct contact with the mental health system and community mental health resources; and
  - c. Peer learning: instituting a model of peer-to-peer education within divisions, such as discussions with officers who have experience with mental health issues in their families, who have worked on an MCIT, who received Crisis Intervention Team (CIT) training, or who have other related experience.

17. The TPS collaborate with researchers or sponsor research in the field of police education to develop a system for collecting and analyzing standardized data regarding the effectiveness of training at the TPC, OPC, and the divisional levels, and to measure the impact that improvements in training have on actual encounters with people in crisis.
18. The TPS consider whether a broader range of perspectives can be considered in designing and delivering mental health training, for example, by involving TPS psychologists, Police College trainers, additional consumer survivors, mental health nurses and community agencies who work with patients and police.
19. The TPS further refine its selection and evaluation process for coach officers and supervisory officers to ensure that the individuals in these roles are best equipped to advise officers on appropriate responses to people in crisis; in particular, that the TPS:
  - a. Consider requiring additional mental health training and/or experience for candidates interested in coach officer and sergeant positions, such as CIT training or MCIT experience;
  - b. Create an evaluation mechanism through which officers can provide anonymous feedback on their coach officers or supervisors, including feedback on their skills regarding people in crisis; and
  - c. Ensure performance evaluation processes for supervisors include evaluation of both their skills regarding mental health and crisis response, as well as their monitoring of their subordinates' mental health and wellness;
20. The TPS create a Service-wide procedure for debriefing, including the debriefing of incidents involving people in crisis and incidents involving use of force, which includes consideration of such factors as:
  - a. Discretion: the circumstances under which debriefing is mandatory, as opposed to when it is subject to the discretion of the appropriate supervisor;
  - b. Participants: which members should participate in the debriefing process, particularly where there is a risk of re-traumatizing an officer suffering from critical incident stress;
  - c. Institutional Learning: how the learning points from the debriefing can be shared with other members of the Service;
  - d. Process: the appropriate circumstances, methods, and selection of appropriate personnel for debriefing incidents that involved people in crisis, whether they were resolved successfully or resulted in unsatisfactory outcomes;
  - e. Timing: how to create an expectation that debriefs will be conducted immediately after an incident, where appropriate, to encourage learning through debriefs without the fear of resulting sanctions;
  - f. Self-analysis: whether the incident was resolved with the least amount of force possible, as well as whether the officer experienced fear, anxiety, and other psychological and emotional effects during the encounter, and techniques for coping with those effects while trying to de-escalate a situation;
  - g. Direct Feedback: direct feedback to officers on incidents that could have been resolved with less or no force, including whether the officer considered inappropriate circumstances or failed to consider appropriate factors and any alternative force options that could have been employed;

- h. Critical Incident Response: the importance of conducting debriefs in a manner that respects officers' mental health needs following an incident of serious bodily harm or lethal force, and the role of the Critical Incident Response Team;
  - i. Stigma: how to foster discussions regarding stereotypes or misconceptions about people in crisis that may have contributed to the officer's decision-making during the crisis situation; and
  - j. Valuing the Role of Debriefs: methods for creating a culture of debriefing and self-assessment within the Service, rather than a systemic perception of debriefing as a routine administrative duty.
21. The TPS develop a procedure that permits debriefing to occur on a real-time basis despite the existence of a Special Investigations Unit (SIU) investigation. The TPS should work with the SIU and appropriate municipal and provincial agencies to craft a procedure that does not interfere with external investigations and that maintains the confidentiality of the debriefing process in order to promote candid analysis and continuous education.
22. The TPS develop a network of mental health champions within the Service by appointing at least one experienced supervisory officer per division with experience in successfully resolving mental health crisis situations to:
- a. provide formal and informal divisional-level training, mentoring, and coaching to other officers;
  - b. lead or participate in debriefings of mental health crisis calls when appropriate;
  - c. provide feedback to supervisors and senior management on officers who deserve recognition for exemplary conduct when serving people in crisis and those who need additional training or coaching;
  - d. meet periodically with other mental health champions at various divisions to discuss best practices, challenges, and recommendations; and
  - e. report to the appropriate deputy chief or command officer on the above responsibilities.
23. The TPS establish an appropriate early intervention process for identifying incidents of behaviour by officers that may indicate a significant weakness in responding to mental health calls. Relevant data would include: propensity to draw or deploy firearms unnecessarily; use of excessive force; lack of sensitivity to mental health issues; insufficient efforts to de-escalate incidents; and other behaviours.
24. The TPS review its discipline procedure with regard to the following factors:
- a. Consistency: whether appropriate consequences are consistently applied to penalize inappropriate behaviour by officers in connection with people in crisis;
  - b. Appropriate Penalties: whether officers who demonstrate conduct inconsistent with the role of a police officer are appropriately disciplined, including through suspension without pay or removal from their positions when appropriate;
  - c. Supervisory Responsibility: whether there are appropriate disciplinary consequences for supervisors who fail to fulfil their duties to identify and rectify weaknesses in training or performance by officers subject to their oversight;
  - d. Use of Force Reports: whether the information recorded in previous Use of Force Reports could be used in determining the appropriate level of discipline in particular incidents involving excessive use of force; and

- e. Legislative Reform: whether the factors listed above require the TPS to work with the provincial government to modify legislative or regulatory provisions.
25. The TPS create incentives for officers to put mental health training into practice in situations involving people in crisis, and to reward officers who effectively de-escalate such crisis situations. In this regard, the TPS should consider inviting community organizations or other agencies to participate in determining division-level and Service-wide awards for exceptional communications and de-escalation skills.
26. The TPS consider revising the process for performance reviews and promotions to :
- a. establish an explicit criterion that experience with people in crisis will be considered in making promotion decisions within the Service;
  - b. place a greater emphasis on crisis de-escalation skills such as communication, empathy, proper use of force, patience, and use of mental health resources; and
  - c. determine the appropriate use of information contained in Use of Force Reports in assessing an officer's performance and suitability for promotion or particular job assignments.
27. The TPS enforce, in the same way as other TPS procedures, those procedures that require an officer to attempt to de-escalate, such as Procedure 06-04: Emotionally Disturbed Persons. In particular:
- a. Professional Standards investigations under Section 11 of Regulation 267/10 under the Police Services Act should investigate whether applicable de-escalation requirements were complied with, and if not, a finding of contravention of Service Governance and/or misconduct should be made;
  - b. in appropriate cases, officers who do not comply with applicable de-escalation requirements should be subject to disciplinary proceedings; and
  - c. supervisory officers should be formally directed to
    - i. monitor whether officers comply with applicable de-escalation requirements, and
    - ii. take appropriate remedial steps, such as providing mentoring and advice, arranging additional training, making notations in the officer's personnel file, or escalating the matter for disciplinary action.
28. The TPS create a formal statement on psychological wellness for TPS members. This statement should:
- a. acknowledge the stresses and mental health risks that members face in the course of the performance of their duties;
  - b. confirm the Service's commitment to providing support for members' psychological wellness;
  - c. emphasize the importance of members attending to their mental health needs;
  - d. emphasize the importance of members monitoring the mental health of their colleagues, and assisting colleagues to address mental health concerns;
  - e. emphasize the role of supervisory officers in monitoring the mental health of those under their command, and in intervening to assist where appropriate;
  - f. set out the psychological wellness resources available to members of the Service; and

- g. be accessible online and used in training at all levels of the Service.
29. The TPS consider whether to establish a comprehensive psychological health and safety management system for the Service.
30. The TPS provide a mandatory annual wellness visit with a TPS psychologist for all officers within their first two years of service.
31. The TPS consider providing less frequent periodic mandatory wellness visits with a TPS psychologist or other counsellor for all police officers or, if it is not immediately possible to provide wellness visits to all officers, for any officer who works as a first responder, coach officer, or supervisory officer. The TPS should also encourage all officers to seek counselling voluntarily.
32. The TPS promote a greater understanding of the role and availability of the TPS psychologists, the EFAP [employee and family assistance program] and peer support groups as confidential resources that officers are encouraged to make use of to help them stay mentally healthy.
33. The TPS consider whether it would be helpful to establish an Internal Support Network for people who have experienced a shooting or other traumatic incident, or more generally to help officers with work-related psychological stresses.
34. The TPS consider creating a new procedure, substantially modelled after Procedure 08-05 “Substance Abuse” in order to address members’ mental health, and specifically to require officers in supervisory roles to monitor for mental health concerns of TPS members under their command, in order to identify means of providing help for mental health issues before a fitness for duty issue arises.
35. The TPS provide officers in supervisory roles with training specific to monitoring other officers’ psychological wellness and guiding preventive intervention where it is warranted.
36. The TPS revise its Use of Force Procedure to supplement the Ontario Use of Force Model and guidelines with best practices from external bodies such as the IACP, the United Nations, and other police services in order to:
  - a. incorporate approaches to minimizing the use of lethal force wherever possible;
  - b. increase the emphasis placed on the seriousness of the decision to use lethal force in response to a person in crisis;
  - c. further emphasize lethal force as a last resort to be used in crisis situations only where alternative approaches are ineffective or unavailable;
  - d. articulate the importance of preserving the lives of subjects as well as officers wherever possible;
  - e. recognize indicators of mental health crises as symptoms rather than threats to officer safety;
  - f. acknowledge that many mental health calls result from crisis symptoms rather than criminal behavior;
  - g. emphasize that police responding to people in crisis are usually required to play a helping role, not an enforcement role; and
  - h. articulate that communication with a person in crisis should be a default technique in all stages of assessing and controlling the situation and planning a response.

37. The TPS regularly update its Use of Force Procedure to reflect best practices and the results of further research into the most effective means of communicating with people in crisis. In this regard, the TPS should seek alternative approaches for officers when a person in crisis does not appear to comprehend or have the ability to comply with the Police Challenge; and consider consulting with provincial agencies, the Ontario Police College, mental health experts, consumer survivors, and others with specialized experience to ensure that the Use of Force Procedure reflects best practices.
38. The TPS expand the availability of MCIT to provide at least one MCIT unit per operational division. The following matters related to expanding MCIT should be addressed, in cooperation with applicable Local Health Integration Networks and partner hospitals:
  - a. Hours: Whether MCIT service should be provided 24 hours per day;
  - b. First Response: Whether MCIT can act as a first response in certain circumstances; and
  - c. Alcohol and Drugs: Whether MCIT can respond to calls involving alcohol or drug abuse.
39. The TPS require all coach officers and supervisory officers to attend the training course designed for MCIT officers so that they gain greater awareness of mental health issues and the role of specialized crisis response.
40. The TPS encourage supervisory officers, coach officers, and others with leadership roles to promote awareness of the role of the MCIT program within the TPS so that all frontline officers know the resources at their disposal in helping a person in crisis.
41. The TPS, as part of training at the platoon level, include sessions in which MCIT units educate other officers on the role of the MCIT unit and best practices for interacting with people in crisis.
42. The Chief of Police strike an advisory committee, to advise the Chief of Police on how best to implement the recommendations contained in this Report. In this regard, I recommend:
  - a. Stakeholder Membership: The advisory committee should include leading members of key stakeholder groups, including hospitals, community mental health organizations, the police and those with lived experience of mental illness;
  - b. Limited Membership: The advisory committee should be of manageable size—large enough to provide adequate representation of stakeholder groups but small enough to be efficient;
  - c. Advisory Role: The advisory committee should play only an advisory role and should not have decision-making authority, unless the Chief of Police determines otherwise;
  - d. Defined Role: The role of advisory committee members should be defined in clear terms at the time of the creation of the advisory committee, so that there is no misunderstanding as to their function and authority;
  - e. In Camera Meetings: The discussions of the advisory committee should be held in camera in order to promote candour and collegiality, unless otherwise directed by the Chief of Police. Advisory committee members should agree as a condition of membership that they will not disclose the committee's discussions;
  - f. Communications with the Public: The advisory committee and its individual members should not advocate publicly or use the media as a vehicle for seeking to persuade the Chief of Police (or the TPS more broadly) to make specific decisions or to

criticize the TPS. The advisory committee should not be a political body but rather a true advisory body, with the effectiveness of its advice deriving from the quality of its membership;

- g. Staffing: The advisory committee should be provided with reasonable assistance by staff as needed, whether using existing TPS personnel or otherwise; and
  - h. Annual Reports: The advisory committee should prepare annual reports for the Chief of Police, summarizing the state of progress in implementation, any significant divergences between the advice of the committee and the decisions taken by the TPS in the past year, and major recommendations going forward relating to implementation, prioritization, scheduling, planning, resource allocation, public reporting, and related topics.
43. In order to ensure transparency and accountability during the implementation stage, the TPS issue a public report at least annually after the date of release of this Report, with the following contents:
- a. a list of recommendations implemented in whole or in part to the date of the report, with an explanation of what was done and when;
  - b. a list of those recommendations still to be implemented, with an indication of the anticipated timing of implementation;
  - c. if applicable, a description of resource constraints that affect the ability of the TPS to implement any recommendations, or the timing of implementation;
  - d. if applicable, a description of any other limitations on the ability of the TPS to implement any recommendations (such as lack of cooperation from other organizations, change in circumstances, etc.);
  - e. if applicable, a list of recommendations that the TPS decided not to implement at all, and an explanation of the reasons for decision;
  - f. if applicable, a list of recommendations that the TPS decided to implement in modified form (different from what was recommended in this Report), and an explanation of the reasons for decision; and
  - g. a discussion of any significant divergences between the advice of the advisory committee and decisions made by the TPS.
44. The Chief of Police and the Executive Management Team of the TPS play a significant leadership role in requiring implementation of the recommendations in this Report, and in encouraging (through leadership by example and otherwise) voluntary compliance.
45. The TPS appoint a senior officer to assume overall operational responsibility and executive accountability for the implementation of the recommendations in this Report, subject to the direction of the Chief of Police or the Chief's designate.
46. The TPS create an implementation team, led by the senior officer identified above and composed of those TPS members charged with responsibility to implement recommendations within specified areas of the Service (e.g., within the MCIT program, within Psychological Services, within the Toronto Police College, etc.).
47. The Chief of Police or [their] delegate appoint, within each TPS division and unit, at least one TPS member formally charged with responsibility for ensuring effective implementation of the recommendations in this Report at the division or unit level.

48. In connection with those recommendations above that call for further study, examination, and analysis of specific issues:
- a. Stakeholder Input: Where appropriate, the TPS seek to involve representatives of affected stakeholders meaningfully in the work;
  - b. Deliverables: The TPS identify specific deliverables sought from those tasked with the work, and a timeframe for delivery; and
  - c. Reporting Requirement: There be a regular reporting requirement for any work taking place over an extended period, whereby the senior TPS officer in charge of implementation is kept informed regarding the progress of the work.
49. In connection with those recommendations above that call for the TPS to work with outside organizations such as government ministries, hospitals, and others, the TPS take a leadership role in forging and fostering the necessary relationships.
50. The TPS collaborate with academic researchers, hospitals, and others to evaluate the effectiveness of TPS initiatives undertaken as a result of this Review, including, where applicable, both quantitative and qualitative evaluations.
51. A follow-up review be conducted—whether by TPS personnel, by an independent review body, or by committee of interested stakeholders—in five years’ time to assess the degree of success achieved in minimizing the use of lethal force in encounters between the TPS and people in crisis and to make further recommendations for improvement. I recommend that the results of that review be made public and that the reviewers be similarly tasked with developing recommendations for implementation.

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### **2.2.9. Chairperson-Initiated Complaint and Public Interest Investigation regarding Policing in Northern British Columbia (Civilian Review and Complaints Commission for the RCMP, 2017)<sup>129</sup>**

This review was initiated in 2013 in response to reports regarding policing in northern British Columbia, including the Missing Women Commission of Inquiry (summarized below in section 3.5.), and in response to several specific police-related incidents in the region. Northern BC is policed by the RCMP “E” Division North District, which includes 35 detachments and satellite offices. The review focused on the conduct of RCMP members in the region relating to cross-gender police searches, publicly intoxicated people, missing persons and domestic violence reports, the use of force, and files involving youth.

The Commission noted that human rights and civil liberties organizations had raised concerns that the RCMP in northern BC were failing to conduct thorough investigations, inconsistently applying intimate partner violence (IPV) policies, failing to conduct risk assessments, and improperly arresting women acting in self-defence. The Commission also noted that witnesses speaking to the Commission said that the police do not take action in domestic disputes “until something actually happens” and that the RCMP is slow to respond to calls regarding intimate

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<sup>129</sup> “Chairperson’s Final Report after Commissioner’s Response.” Chairperson-initiated Complaint and Public Interest Investigation regarding Policing in Northern British Columbia (February 2017), <https://www.crc-ccecp.gc.ca/pdf/northernBC-finR-en.pdf>. See also Bob Paulson. “Commissioner’s Response to Interim Report.” (July 2016) [northernBC-commResponse-en.PDF \(crc-ccecp.gc.ca\)](https://www.crc-ccecp.gc.ca/pdf/northernBC-commResponse-en.PDF) and Civilian Review and Complaints Commission. “Report on Policing in Northern British Columbia – Backgrounder.” [Report on policing in northern British Columbia – Backgrounder | Civilian Review and Complaints Commission for the RCMP \(crc-ccecp.gc.ca\)](https://www.crc-ccecp.gc.ca/pdf/northernBC-commResponse-en.PDF).

partner violence when there are no members present in the community or detachment office. The Commission reviewed a sample of occurrence reports involving IPV from 2011 and 2012. It found several problems with the supervision of members conducting IPV investigations. Non-commissioned officers (NCOs) interviewed by the Commission confirmed that inconsistent supervision of IPV files was a concern. They attributed these inconsistencies to vacancies in supervisory positions and the steep learning curve for new supervisors in the region. The Commission noted that the quality of IPV investigations improved markedly after supervisory positions were staffed and all Constable positions were filled.

The Commission noted that the RCMP Operational Manual contained a policy on intimate partner violence (referred to as “Violence in Relationships”). The policy directed RCMP members to investigate and document all complaints of violence in relationships. Member discretion was described as “very narrow”: IPV investigations are a priority, and members have a duty to lay or recommend charges if a Criminal Code offence has been committed. The policy highlighted the serious and unpredictable nature of IPV and reminded members to consider all options in determining the appropriate cause of action. Under the policy, supervisors are expected to closely monitor these investigations to ensure that all investigative procedures are taken and are required to recommend or approve the laying of charges and are required to document in writing a decision not to charge. Commanders must ensure these complaints are investigated and supervised and that appropriate action is taken. The national policy emphasized the need for prevention, enforcement, victims’ safety, and public safety. The Commission found that this policy provided appropriate guidance and ensured appropriate quality assurance and accountability. However, it noted that the policy stated that “if practicable,” the member should obtain victim and witness statements. The Commission recommended strengthening the requirement to obtain victim and witness statements except in exigent circumstances and requiring members to document the reasons they did not obtain the statements. The policy on seizing weapons in cases of IPV was also confusingly written and could be misleading.

The national RCMP policy also required each division to create its own divisional policy. The Commission reviewed “E” Division’s policy and found that it provided for adequate quality assurance and oversight of investigations into intimate partner violence cases. The “E” Division policy as described by the Commission was detailed and mirrored British Columbia’s IPV policy at the time.

The Commission also reviewed the training received by RCMP Cadets relating to IPV. Cadets at that time received a 32-hour module on IPV-related training, which was focused on the practical aspects of investigations and included exercises, readings and research, role plays, panel presentations, and discussion. The modules taught other subject matter at the same time, such as weapons assessments and witness interviews.<sup>130</sup> Although the Commission found that the training provided members with the basic skills and competencies to deal with IPV situations, it noted that the module dedicated only fifteen minutes to reviewing the national policy and advised cadets that local divisions may have more specific directions. The Commission did not state whether the training included any information on the social context of IPV or other issues, and it does not appear that risk assessment specific to intimate partner violence and gender-based violence was covered.

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<sup>130</sup> It is unclear from the description in the Report whether all of this training is focused on IPV or whether IPV is an ancillary or coincidental aspect of this training. For example, a session on witness interviews could use an IPV scenario but not teach techniques specific to IPV investigations.

The Commission noted that all police officers in BC who may attend, follow up or supervise calls involving IPV (which is most if not all officers) were required to take two online, interactive IPV training courses provided by the provincial Ministry of Justice. The courses focused on proactive and collaborative approaches to IPV cases, documenting IPV cases, and promoting victim safety.

The Commission also found that the “E” Division North District officers had failed to promptly and thoroughly investigate nearly half of the missing persons reports they received from 2008 to 2012. There was also poor supervision in missing persons cases, and cases were often improperly coded, in some instances deliberately in order to avoid the paperwork required in cases coded as “missing persons” cases. The Commission also expressed concern about whether the RCMP in northern BC had in fact reviewed all unsolved cases of missing or murdered Indigenous women, as the RCMP had committed to do.

A review of the outcomes of apprehensions of Indigenous women for public intoxication showed that significantly more Indigenous women than Caucasian women were incarcerated and held until sober; more than four times as many Caucasian women than Indigenous women were taken home. There were similar results for Indigenous youth compared with Caucasian youth. However, the Commission stated it was unable to conclude from the data that there was differential treatment of Indigenous women and youth.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 21) That the RCMP ensure that yearly unit-level quality assurance and/or management reviews always include a review of violence in relationships investigations;
2. (Recommendation 23) That the RCMP amend section 2.2.4. of National Headquarters Operational Manual chapter 2.4. to enhance accountability by requiring members who do not obtain victim and witness statements to document the reasons they were not obtained;
3. (Recommendation 24) That the RCMP amend section 2.2.7. of National Headquarters Operational Manual chapter 2.4. to make it consistent with the search and seizure provisions in section 117.04. of the Criminal Code;
4. (Recommendation 31) That in the interest of promoting a standardized approach and to support effective, comprehensive, and coordinated responses to missing persons investigations, the RCMP consider making training on the revised national missing persons policy requirements mandatory for members in contract policing.

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#### **2.2.10. Independent Police Oversight Review (Ontario, 2017)<sup>131</sup>**

In 2016, the Government of Ontario appointed Justice Michael Tulloch of the Court of Appeal for Ontario to review the province’s three civilian police oversight bodies: the Special Investigations Unit (SIU), which investigates incidents involving police that cause serious injury or death to civilians; the Office of the Independent Police Review Director (OIPRD), which considers complaints about Ontario police officers by members of the public; and the Ontario Civilian Police Commission (OCPC), which is responsible for deciding appeals of disciplinary hearings by police officers. Justice Tulloch was required to identify measures to improve the transparency, accountability, effectiveness, and efficiency of these bodies. He was also asked to consider how

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<sup>131</sup> “Report of the Independent Police Oversight Review.” Submitted to the Attorney General of Ontario (31 March 2017), <http://www.policeoversightreview.ca/policereport.html>.

they could improve interactions with Indigenous people and to consider additional specific questions about the staffing of these bodies, the legislative framework, information-sharing between these bodies, and the collection of demographic information. Although Justice Tulloch was not permitted by his terms of reference to comment on any specific case, this review was prompted in part by protests among members of the Black community following the 2015 death of Andrew Loku, a Black man with mental health difficulties. Police responding to a 911 call shot Mr. Loku within seconds of their arrival. Mr. Loku was holding a hammer at the time. The SIU concluded that the officer who shot Mr. Loku was justified in his use of force.<sup>132</sup> Justice Tulloch was not permitted by his terms of reference to comment on any specific case.

Justice Tulloch and his team held seventeen public consultations and over 130 private meetings, with a total of more than 1500 people in seven months. He travelled all over Ontario to do so. He also examined oversight bodies in other jurisdictions and considered past reports on Ontario's system of public oversight.

In his report, Justice Tulloch reviewed the history of policing in Canada. He noted that a fundamental principle of policing is that “the special authority bestowed on the police is at the behest of the public and is to be exercised in the public interest.”<sup>133</sup> This is the basis for public confidence in the police. Justice Tulloch then examined the history of policing in Black and Indigenous communities. He noted that “Indigenous-police relations are directly tied to a history of colonialism.”<sup>134</sup> Indigenous people are now less likely to engage with the police or their oversight bodies partly as a result of this history. Similarly, the relationship between Black Canadians and police was initially formed in the context of slavery in Canada, which was enforced through slave patrols. Black communities feel they have always been over-policed and stereotyped as criminals. Justice Tulloch concluded from his consultations that the distrust of police extends to police oversight bodies. The SIU rarely lays charges and provides little information to the public, and the OIPRD screens out most complaints or returns them to the police for investigation.

Ontario is policed by approximately 60 municipal police services and by the Ontario Provincial Police (OPP). The OPP patrols provincial highways, investigate major crimes that affect the province or country, and provides local police services for communities that do not have their own municipalities or that contract with the OPP, similar to the RCMP in most other provinces. Internal complaints are dealt with by municipal chiefs of police or by the OPP Commissioner. Ontario's police are governed by the Police Services Act.

Justice Tulloch noted that “[t]he public's voluntary conferral of powers on the police comes with a commensurate right to ensure that those powers are being used properly and effectively.”<sup>135</sup> He then reviewed the history of civilian oversight of police in Ontario. This history shows numerous efforts over several decades to find a satisfactory model of oversight. Institutions were created, reviewed, revamped, and replaced, against a backdrop of police shootings and allegations of police misconduct, particularly in Black communities in Toronto.<sup>136</sup> Justice Tulloch identified ten

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<sup>132</sup> See the attachment to letter from Across Boundaries to Toronto Police Services Board dated July 14, 2020 (OCC Inquest – Loku 2017),

[http://www.tpsb.ca/media/breezingforms/uploads/Letter\\_to\\_TPSB\\_July\\_14\\_2020\\_Attachments.docx](http://www.tpsb.ca/media/breezingforms/uploads/Letter_to_TPSB_July_14_2020_Attachments.docx).

<sup>133</sup> “Report of the Independent Police Oversight Review,” chapter 1, paragraph 5.

<sup>134</sup> “Report of the Independent Police Oversight Review,” chapter 1, paragraph 23.

<sup>135</sup> Para 35

<sup>136</sup> This history is set out in chapter 3, paragraphs 108–34.

reviews and task forces that had issued recommendations on police oversight between 1988 and 2011.

### **Special Investigations Unit**

The Special Investigations Unit (SIU), established in 1990, investigates serious injuries and deaths where police officers are involved, including sexual assault. It can lay criminal charges against officers where there are reasonable grounds supporting the charge. At the time of Justice Tulloch's Report, the SIU was governed by the Police Services Act. It was established as a "unit" under the Ministry of the Solicitor General. In practice, it is allowed to operate as an arm's-length agency and functionally operates under the Ministry of the Attorney General. Its director is appointed by the Lieutenant Governor in Council and cannot be a former police officer. Investigators can be former police officers but cannot investigate members of police forces they have worked for. The SIU must be notified immediately of any incident that could fall within its mandate, and the scene must be secured for their investigators. Officers involved are separated from each other until after their interviews by the SIU. "Subject officers," who are those who appear to have caused the injury or death, do not have to provide their notes to the SIU or be interviewed. They may do so voluntarily. "Witness officers," who are those involved but are not subject officers, are required to provide their notes and be interviewed. Both subject and witness officers are entitled to have counsel present during interviews with the SIU.<sup>137</sup> If at the end of the investigation, the SIU director determines there are reasonable grounds to believe an officer has committed a criminal offence, the officer will be charged.<sup>138</sup> The Crown then screens the charge to consider whether there is a reasonable prospect of conviction and whether a prosecution is in the public interest. (Crown Attorneys conduct this screening for all charges in Ontario.) If the director decides not to lay a charge, they provide the Attorney General with a written report setting out the evidence and rationale for this decision. This report is typically seen only by the Attorney General. Out of 3932 incidents between 2002 and 2016, the SIU laid charges in 129 cases.

The SIU was established in 1990 following the shooting deaths of two black men by police, in order to improve public confidence in policing. However, Justice Tulloch noted that over 25 years later, Ontarians, particularly those from Indigenous, Black, and other racialized communities, suggested that this objective had not been achieved.

Justice Tulloch recommended that the SIU be made a separate agency, accountable to but arm's length from the Ministry of the Attorney General. This would make the SIU more accountable, as it would be required to post annual reports to the public and be subject to mandatory reviews. It would also enhance the SIU's independence. Although the SIU had been permitted to act independently, independence should not be left to the discretion of the minister of the day.

### **Office of the Independent Police Review Director**

The Office of the Independent Police Review Director (OIPRD) was created in 2009. It too is governed by the Police Services Act. The Director cannot have been a police officer, but former

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<sup>137</sup> Civilians suspected of crimes do not have the right to have counsel attend interviews with the police. They can decline such interviews unless they are detained; if they are detained, they have the right to remain silent during an interview.

<sup>138</sup> The language of the statute was mandatory: "If there are reasonable grounds to do so in his or her opinion, the director *shall* cause information to be laid against police officers in connection with the matters investigated and *shall* refer them to the Crown Attorney for prosecution." Police Services Act, s. 113(7), RSO 1990, c.P.15 (emphasis added).

officers can work there. Members of the public may complain to the OIPRD about the conduct of any individual conduct or the policies or services of a police service. Some complaints are addressed through a voluntary process of mediation called “customer service resolution.” Where this process fails, or where complaints are not appropriate for this process, the complaints are screened by OIPRD staff. Those which are considered to be frivolous or vexatious, out of time, not in the public interest, or outside of the OIPRD’s jurisdiction are screened out. At any time, those complaints which do not allege serious misconduct may be resolved through a voluntary informal process.

Complaints relating to policies and services must be referred to the municipal chief of police, OPP Commissioner, or OPP detachment commander, who must then notify the OIPRD of their disposition.

Complaints related to conduct can be referred to the chief of police of the force to which the complaint relates, referred to the chief of police of a different force, or investigated by the OIPRD. The majority are referred to the chief of the relevant force. Complaints about chiefs or deputy chiefs are referred to the relevant police services board.

Where the complaint is referred to the chief of the relevant force or to the chief of another force, the force’s professional standards unit then investigates and provides a report to its chief. If the chief believes on reasonable grounds that the officer has engaged in misconduct or unsatisfactory work performance of a serious nature, there will be a disciplinary hearing. If the chief decides the complaint is not substantiated or that the conduct was not serious, the complainant, officer, the chief if the investigation was done by a different force, and OIPRD are notified and no further action is taken. The complainant may request the OIPRD to review the matter. If the OIPRD agrees with the complainant, it instructs the chief how to deal with the complaint. This can include directing the chief to hold a disciplinary hearing.

Where the OIPRD conducts its own investigation, it then provides a report to the chief of the relevant force. It must state whether it has substantiated the complaint and, if so, whether the misconduct or unsatisfactory work performance was serious in nature. Serious matters will proceed to a disciplinary hearing.

The disciplinary hearings that result from OIPRD complaints are conducted by police services in the same manner as internal disciplinary matters, which are considered employment matters. The chief designates the prosecutor and the hearing officer. If the prosecutor satisfies the hearing officer on clear and convincing evidence that the officer has engaged in misconduct (violation of the Police Code of Conduct or other activity set out in the legislation), the officer can be dismissed, demoted, suspended, reprimanded, or directed to undergo specified counselling or training. The officer and complainant both have a right of appeal to the Ontario Civilian Police Commission (see below). The chief of police and OIPRD do not have any rights of appeal. The OIPRD is not involved in the hearing.

The OIPRD also reviews systemic issues identified by public complaints, such as the use of force when interacting with people in crisis and canvassing the public for DNA samples.

### **Ontario Civilian Police Commission**

The Ontario Civilian Police Commission (OCPC) succeeded the Ontario Civilian Commission on Police Services, which in turn succeeded the Ontario Police Commission. It is an adjudicative body that hears police of police disciplinary decisions, determines budget disputes, and

investigates the conduct of police officers, chiefs of police, and members of police services boards. It can also direct municipal police forces and police services boards to comply with policing standards and sanction those who fail to do so. It also approves municipal detention facilities and adjudicates appeals regarding officers who have been discharged or retired due to disability. Most of its work focuses on disciplinary appeals. The OCPC has the power to revoke or change a hearing officer's decision and can substitute its own decision or order a new hearing. It is governed by the Police Services Act.

### **Overall Findings and Recommendations**

Justice Tulloch made the following overall findings and recommendations:

The current legislative framework is a patchwork of amendments over the years. The Police Services Act largely focuses on labour relations for police officers, such as collective bargaining and pensions. The provisions about the oversight bodies are scattered throughout the statute and mixed in with internal governance provisions. Justice Tulloch found that the public must have confidence that the oversight bodies are independent, or they won't engage with those bodies. The appearance that the oversight bodies are part of the internal police discipline function erodes that confidence. He recommended that each oversight body be the subject of separate legislation. That would build public confidence in their independence. It would also make it easier for members of the public, particularly those with a complaint about police, to understand how the organization works. The new legislation should also be user-friendly and easy to understand.

All three oversight bodies should report to the Ministry of the Attorney General, as that is the ministry responsible for upholding the rule of law. The leadership and staff at all three oversight bodies must be socially and culturally competent. That competence requires an understanding of the community's history and relationship with police and police oversight. It also requires understanding the differential treatment experienced by women, racialized people, those affected by mental health issues and disabilities, and understanding the power imbalances in domestic relationships. He recommended the oversight bodies implement mandatory, comprehensive, and permanent training and evaluation programs to address these issues, in partnership with organizations working with women, LGBTQ communities, people with mental and physical disabilities, and race-based organizations. The success of these training programs should be tracked using key performance indicators. The organizations should also make efforts to recruit staff from diverse communities.

The SIU and OIPRD did not have security of tenure. Security of tenure is important for independence, as it promotes freedom from political interference. A director with a fixed term will not fear dismissal for speaking out about civilian oversight issues.

The SIU had struggled over the years to understand its public accountability function. Justice Tulloch believed this was in part due to the lack of diversity among its directors. Investigations had also been prioritized over public accountability (which was reflected in the fact that the current executive officer, responsible for both investigations and outreach, was a former police officer). Justice Tulloch recommended a new leadership structure and resourcing that would give more prominence to public accountability.

There was a lack of trust between the SIU and many communities it serves, particularly Black and Indigenous communities and people with mental health challenges, who have been disproportionately affected by incidents in which the SIU was involved. Better community outreach could improve that trust.

There had also been serious delays in investigations, in part because the SIU director is responsible for all charging decisions.

Very few resources were directed toward supporting those people affected by the incident leading to the investigation, through referrals to counselling and victim support services and liaising with investigators. Investigators were generally not trained to deal with people experiencing grief and trauma, and they also often carried themselves like police officers, which could cause distress to affected people.

Justice Tulloch determined that although having former police officers acting as SIU investigators can lead the public to question whether they are biased in favour of the officers they investigate, they should not be prevented from doing so. He noted that no prior review had recommended that former police officers be barred from acting as SIU investigators, and all other oversight bodies in Canada and the United Kingdom employed former police officers. (He noted that most Canadian equivalents of the SIU have a blend of investigators who do not have a background in policing and those who do; Nova Scotia was the only province identified that did not employ any investigators with non-policing backgrounds.<sup>139</sup>) Justice Tulloch was of the view that the SIU should not prevent former officers from working as investigators but should increase the number of investigators who do not have a policing background. The SIU should also implement anti-bias measures into the recruitment, training, and evaluation of its investigators. He agreed with the conclusion reached by Stephen Lewis in his 1992 report on police oversight, in which he stated,

Criminal investigation takes years and years of experience to acquire, and in the process of investigation, there is equally the need to be intimately familiar with police culture. Independence must absolutely be assured, but it should be possible to find and attract skilled police criminal investigators of excellence, who would wish to join the Special Investigations Unit because they believe, above all, in a fair, law-abiding and incorruptible police force, and they're prepared to devote their careers to that end.<sup>140</sup>

Similarly, the OIPRD should also be less reliant on investigators who do not have policing background, particularly given that they do not undertake criminal investigations, and bias concerns should be addressed through recruitment, training, and evaluation initiatives.

He also recommended that SIU and OPIRD investigators be accredited, but not through the Ontario Police College, given that its investigation training is not designed to meet the requirements of oversight bodies.

Justice Tulloch noted that the Ontario Ombudsman has jurisdiction to hear complaints about the SIU. However, it cannot hear complaints about the OIPRD and OCPC. He recommended that its mandate extend to all three oversight bodies.

Justice Tulloch also made recommendations designed to strengthen the SIU's investigative capacity. He noted that the SIU complains that police often take a strict interpretation of their obligations to cooperate with investigations, and police complain that the SIU oversteps its mandate and powers. He there recommended that the SIU mandate be clarified in its governing legislation to specify the meaning of "serious injury," the officers over whom it has jurisdiction, and

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<sup>139</sup> "Report of the Independent Police Oversight Review," chapter 4, paragraph 167. As of February 2022, according to the website of the Nova Scotia Serious Incident Response Team (SIRT), each of its investigators has a background in policing. Two are former RCMP officers, one is a seconded RCMP officer, and one is a seconded Halifax Regional Police officer. The Director is a retired judge. See <https://sirt.novascotia.ca/about>.

<sup>140</sup> Quoted in "Report of the Independent Police Oversight Review," chapter 4, paragraph 158.

that the police duty to notify the SIU also be clarified. He also recommended that the SIU mandate be expanded to require them to investigate any incident in which a police officer has discharged a firearm at a person, whether or not it results in serious injury or death. The SIU should also be able to investigate any other matter involving police conduct when it determines it is in the public interest to do so, such as allegations of breach of trust, corruption, perjury or obstruction of justice, and systemic racism or discrimination. Justice Tulloch noted that this public interest mandate exists in a number of jurisdictions, including Nova Scotia.

Justice Tulloch concluded that although police attitudes towards the SIU had improved over the years, and many officers do assist investigations, the police duty to cooperate with investigations should be expanded and clarified in the governing legislation. As well, a policy that prohibited Crown counsel from relying on notes or statements from subject officers that were compelled during an SIU investigation, known as the “Harnick Directive,” should be revisited to determine if it remains consistent with related case law. The SIU should also be able to impose sanctions on any member of a police service if they fail to cooperate.

Justice Tulloch also concluded that despite the independence of the SIU, it was not seen as independent. In order to regain public trust, not only must it be effective at holding police accountable; it must also be seen to be effective at holding police accountable. If it is not, the public must be able to hold the SIU accountable, which requires transparency in its decision-making. The Report concludes, “There is an overwhelming need for greater transparency in cases where the SIU decides not to lay a charge.”<sup>141</sup> Prior reviews had recommended that the reports be made public, and the police themselves supported making them public. The SIU took the position that witnesses would be reluctant to come forward if they knew what they said would be made public. Witnesses were currently told by the SIU that anything they said would be kept confidential unless they consented or its release was required by law. Justice Tulloch recommended that SIU reports that do not lead to charges should be released in certain circumstances. These public reports should contain summaries of all relevant evidence, including witness statements, the relevant legal standards that were applied, and how the director made the decision. The reports could leave out identifying information about witnesses to address concerns about privacy. The SIU should also release reports, prepared by the Ministry of the Attorney General, about certain past decisions not to charge.

Justice Tulloch also determined that when a subject officer is charged, they should be named in the SIU press release (noting that accused police officers do not enjoy any special status or privileges in court, and the fact of the charge and their name are part of the public record); but the names of subject officers who are not charged should not be released.

Justice Tulloch noted that effective oversight in Ontario depends in part on the willingness of members of the public making complaints against police officers. He said it is “no easy feat” for members of the public to do so. Many people had told Justice Tulloch during his consultations that they had experienced or witnessed misconduct by police but had never made a formal complaint. He concluded that this failure of the system to draw out meritorious complaints affects the legitimacy of the oversight regime. He identified a number of problems with the OIPRD, including a lack of resources, a lack of transparency and accountability, and a lack of accessibility.

People were reluctant to make complaints for five reasons. Some were not aware of the OIPRD and did not know there was an independent body to whom they could complain. Some mistrusted

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<sup>141</sup> “Report of the Independent Police Oversight Review,” chapter 6, paragraph 84.

the process, particularly the fact that most complaints are referred to the police service for investigation; some feared reprisals by the police, including a belief among vulnerable communities that police would refuse to respond to calls for service or would respond with abuse and violence. Members of Black and Indigenous communities were particularly concerned about complaining against police, given their historical experience with police. Many, including legal professionals, believed it was not worth the effort, given the small number of complaints that lead to a hearing and the perceived minor nature of the penalties imposed when officers were found guilty of misconduct. The lack of supports for complainants also deters them from filing, particularly for members of vulnerable groups such as people with mental health problems, newcomers to Canada, and the homeless. Justice Tulloch made a number of recommendations to improve the public awareness of and perception of the OIPRD, including changing its name, public awareness campaigns, and broadening its mandate to conduct investigations without a complaint where it is in the public interest.

He also noted that the OIPRD, unlike many other police complaints bodies, had the power to screen out complaints that were, in the Director's opinion, not in the public interest to investigate. Justice Tulloch recommended that either the "public interest" ground for screening be eliminated or its meaning be set out in legislation. He also recommended that people not directly affected by the conduct or policy in question be able to bring complaints, noting it would be efficient and appropriate for community groups and legal aid clinics to bring forward complaints about conduct affecting their clients. He also recommended that the OIPRD have jurisdiction to investigate complaints against chiefs, deputy chiefs, the OPP Commissioner and deputy Commissioner, stating that their differential treatment under the current legislation undermines public confidence in the complaints process.

Justice Tulloch also addressed the OIPRD's practice of referring the investigation of complaints back to the relevant police service or a different police service for investigation. This referral occurs with the majority of complaints, meaning that the police are largely investigating the police. For example, in one year, the OIPRD referred 950 conduct complaints to the officer's own service for investigation; investigating only 161 itself. It referred seven complaints to a different police service. This is because the OIPRD was never resourced to be the main investigator of public complaints against the police; rather, it was intended largely to oversee the complaints process. It is not resourced to investigate all public complaints. Justice Tulloch recommended that over the course of five years, the OIPRD mandate and staffing be changed so it can independently investigate all complaints about police. "Independent and impartial investigation of complaints will help foster public trust in not only the complaints system but policing more generally."<sup>142</sup>

Justice Tulloch also recommended a new process for cases where the OIPRD concludes that the complaint warrants disciplinary proceedings. He concluded that there was a consensus among the public and the police that it is not fair and does not appear to be fair or impartial to have the chief of police choose both the prosecutor and adjudicator when complaints about police go to a hearing. Instead, Justice Tulloch recommended a process whereby the OIPRD would lay a disciplinary charge, which would then be prosecuted or settled by an independent public complaints prosecutor. These prosecutors would be legally trained, and selected and employed by the Ministry of the Attorney General in order to enhance their independence from the police. They would have discretion to withdraw charges, similar to Crown Attorneys. The disciplinary charge would be heard by an independent tribunal, which Justice Tulloch described as a "renewed" OCPC. The OIPRD would not have standing at the hearing, in order to preserve its

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<sup>142</sup> "Report of the Independent Police Oversight Review," chapter 7, paragraph 153.

role as the independent investigator of complaints. Complainants would likely be witnesses but would not have to carry the prosecution or otherwise participate.

The independence of the adjudicator was crucial. Justice Tulloch noted:

Members of the public have legitimate concerns about the current system. They are baffled by an independent civilian agency that turns public complaints over to the police service being complained about, to be adjudicated by an individual selected by the police chief. Independent adjudication of public complaints by the OCPC will eliminate these bad optics and promote a fairer, more transparent process.<sup>143</sup>

Given its role in hearing appeals of disciplinary decisions, the OCPC, which is independent and has the expertise to hear public complaints, would be able to take on the role of hearing officers. Its members are typically cross-appointed to other tribunals, are appointed through a merit-based process, and trained in administrative law principles. Its decisions should be publicly posted and subject to judicial review, like other tribunal decisions.

The Police Complaints Act required the OIPRD (or chief, if the conduct was referred back to a police service) to lay a disciplinary charge within six months of commencing an investigation. Justice Tulloch recommended that this limitation period be abolished and recommended that regular administrative law principles should apply to address concerns about undue delay.

The OIPRD was required to advise complainants, as well as police officers and chiefs, when it screened out a complaint or determined it was not substantiated. The OIPRD also had a practice of providing reasons to complainants when it substantiated complaints, but this practice was not legislated. Justice Tulloch recommended that it be legislated.

Justice Tulloch also recommended that the OIPRD be given additional resources, including investigators with specific relevant training, to conduct systemic reviews of policing issues, such as response to protests, sexual assault reporting, and systemic racism. Those reports should be made public, and the OIPRD should be empowered to require a response to its recommendations from the appropriate chief of police within six months.

Justice Tulloch also made recommendations to enhance the coordination of overlapping investigations and proceedings, such as investigation by the SIU of an injury to a person who is at the same time the subject of a criminal investigation by the police, and information-sharing and cross-referrals by the various oversight bodies. He also recommended that many of the labour relations and policy-related functions legislated in the Police Services Act as belonging to the OCPC, such as approval of policing budgets and categorization of police for collective bargaining purposes, be eliminated in favour of the appropriate ministries and labour relations bodies.

Justice Tulloch was also asked to identify ways to improve Indigenous–police relations. After reviewing the history of police enforcement of anti-Indigenous laws and policies, he wrote:

Given the role of police in enforcing laws and policies of control and assimilation against Indigenous peoples, it is not surprising that the relationships between Indigenous peoples and the police have been poor. These negative tensions have persisted, despite more recent efforts to more actively engage and collaborate with Indigenous peoples on policing issues.

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<sup>143</sup> “Report of the Independent Police Oversight Review,” chapter 8, paragraph 51.

Indeed, over the past several decades, a number of reports, inquiries, and commissions have highlighted the troubled relationship between Indigenous peoples and the police. They have generally been critical of the police, noting the police's insensitivity to cultural considerations when working with Indigenous peoples, lack of engagement with Indigenous communities, and alienation of Indigenous peoples from policing and the justice system.

The systemic under- and over-policing of Indigenous peoples historically and today has caused a deep sense of mistrust and stigmatization in Indigenous communities. The overrepresentation of Indigenous peoples in the criminal justice system, both as victims and offenders, has further strained the already damaged relationship between Indigenous peoples and the police. The treatment of Indigenous peoples by the police has contributed to a sense of distrust and estrangement from the police and criminal justice system as a whole.<sup>144</sup>

After reviewing the complex arrangement of policing of Indigenous communities in Ontario, including some First Nations policing programs, Justice Tulloch identified a number of barriers to the effective oversight of police in Indigenous communities. These included: lack of awareness of options for bringing complaints forward; distrust of the oversight system; lack of representation, sensitivity, and cultural competency in the leadership or staff of oversight organizations; inaccessibility, particularly for Indigenous people living in remote communities or who do not speak English or French; and fear of retribution. Consultation participants also described SIU investigators failing to speak with Indigenous witnesses or engage with their communities. They also identified a significant gap in oversight: First Nations constables (most of whom are not Indigenous) have many of the powers of police officers but are not subject to the existing oversight mechanisms. This gap was seen as further evidence of discrimination against Indigenous people. Justice Tulloch noted that a study had shown in 2006 that Indigenous peoples represented 7.1 percent of all civilians involved in SIU investigations, despite comprising only 1.7 percent of the provincial population.

Justice Tulloch responded to these concerns by recommending significant and comprehensive education on cultural competency within the oversight bodies, increased outreach to and partnership with Indigenous communities and organizations, and increased efforts to recruit and promote Indigenous staff, including in leadership positions. He also noted that cultural competency must exist in the policies and culture of these organizations, not just among individual staff. He therefore recommended that the oversight bodies develop a culturally competent approach to service delivery. Finally, he recommended that they implement ongoing auditing to measure the success of these initiatives.

Justice Tulloch noted that many prior reviews had identified the lack of oversight for First Nations constables and police forces as a problem. He recommended that the province consider whether to expand the mandate of the oversight bodies to include First Nations policing, he but noted that this should be done in consultation with First Nations and that individual First Nations should have the ability to opt out.

Justice Tulloch next considered whether the oversight bodies should collect demographic data. He determined that they should and that this data should include information about the gender, age, race, religion, ethnicity, mental health status, disability, and Indigenous status of complainants and alleged victims. This approach, which has been adopted in other jurisdictions and in other sectors, would support evidence-based public policy, promote accountability, and

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<sup>144</sup> "Report of the Independent Police Oversight Review," chapter 10, paragraphs 21–23.

could build public confidence in both policing and the oversight of policing. Justice Tulloch noted that conversations about racial profiling and police bias were, to date, based largely on anecdotes. Police, policymakers, and advocacy organizations should have data with which to conduct research, identify patterns, and determine the extent and nature of systemic issues. Justice Tulloch recommended the creation of an advisory committee to assist the oversight bodies to determine the best practices for this data collection and publication. This advisory committee should include stakeholders such as civil rights organizations, community groups, law enforcement, as well as academics, the Human Rights Commission, Anti-Racism Directorate, and the Information and Privacy Commissioner.

Finally, Justice Tulloch considered other mechanisms for strengthening police oversight. He recommended improvements to municipal police service boards through improved selection criteria and training. He also recommended the creation of a professional regulatory body for police that would be similar those for colleges of teachers, physicians, and other regulated professions. He noted that a college of policing had been recently established in England and Wales. Justice Tulloch was of the view that this body would not replace the existing oversight mechanisms but would complement them by promoting a culture of professionalism within the police. The establishment of a college of policing in Ontario could assist in changing the police culture and help standardize the training and promotion criteria across the province:

Many stakeholders from inside and outside the police community commented on the indoctrination into police culture which begins as early as initial training. That culture traditionally has been White, male, and hyper-masculine.

Stakeholders told me that training emphasizes traits such as physical strength, stoicism, and loyalty to fellow officers. While those traits are admirable and may be beneficial to the work of a police officer, they should not overwhelm other traditional traits such as empathy and compassion. These other traits are also necessary for officers to engage with the public in a respectful and cooperative manner.

Moreover, I was told that not all police services have the same training and professional development expectations for their officers. For example, all new police officers must complete the basic recruit course from the Ontario Police College. But some police services require additional training before an officer will be hired. And the education and training from the recruit stage onwards often appears to be driven by the particular needs of the individual police services, not by a consistent, province-wide professional standard.

Similarly, the requirements needed to enter and continue in the profession of policing in Ontario remain largely static, ill-defined, and inconsistent. A police officer may be promoted for various reasons. Unlike some other professions, there is no standard educational requirement or degree of professional competence required to move up the professional ladder. One police service, for instance, may have certain expectations or requirements for an officer to attain a particular rank that are not shared by other police services.

The College of Policing would partner with educational institutions to create a curriculum for a professional degree in policing, including education on social and cultural competency, policing vulnerable communities, mental health, intimate partner violence, and anti-racism. This curriculum would be taught at a revamped Ontario Police College. The College of Policing would also do the following:

1. Develop entry level academic requirements for police officers;
2. Set standards for the admission and licensing, promotion, and removal of members of the police profession;

3. Maintain a public registry of its accredited members in a way that is similar to other regulated professional bodies;
4. Develop performance expectations and standards for professional development and accreditation;
5. Deliver social and cultural competency programs for police officers and ensure ongoing professional development and competence; and
6. Develop a set of ethical and professional standards and ensure that officers and police services comply with these standards.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 4.1) The laws on the civilian police oversight bodies should be set out in a statute, and regulations made under that statute, dedicated to civilian police oversight, and separate from the Police Services Act.
2. (Recommendation 4.2) The SIU should be recognized as an arm's length agency accountable to the Ministry of the Attorney General.
3. (Recommendation 4.3) The oversight bodies should develop and deliver mandatory social and cultural competency programs for their staff. Those programs should be developed and delivered in partnership with the communities they serve and organizations supporting those communities.
4. (Recommendation 4.4) There should be ongoing recruitment and development of people from communities under-represented within the oversight bodies, including in senior and leadership positions.
5. (Recommendation 4.5) The SIU director and the Independent Police Review Director should be appointed for a five-year term of office. A person may be re-appointed as director for a second five-year term but may not serve more than two terms. A director's appointment may not be terminated, except for cause.
6. (Recommendation 4.6) When appointing the SIU director, the following additional factors should be considered:
  1. The candidate's understanding of the SIU's dual functions of effective investigations and public accountability;
  2. The candidate's understanding of the needs and concerns of the community of stakeholders the SIU serves; and
  3. The added value that a candidate's work or cultural background would bring to the organization.
7. (Recommendation 4.7) The SIU should have a deputy director of investigations and a deputy director of operations and communications.
8. (Recommendation 4.8) The SIU should create a public accountability office responsible for public communications and should be provided with adequate resources for this function.
9. (Recommendation 4.9) The SIU should enhance its services to affected persons and should be provided with adequate resources for this function.
10. (Recommendation 4.10) Affected persons support staff should make initial contact with affected persons who are not witnesses. They should maintain ongoing, proactive communication with all affected persons throughout an investigation.
11. (Recommendation 4.11) The SIU should enhance its community outreach and should be provided with adequate resources for this function.

12. (Recommendation 4.12) The legislation should be amended to provide the following:
  - The director or deputy director of investigations may lay charges;
  - The deputy director of investigations may not be a person who is a police officer or former police officer; and
  - The deputy director of investigations may designate a person, other than a police officer or former police officer, as acting deputy director of investigations to exercise the powers and perform the duties of that deputy director if that deputy director is absent or unable to act.
13. (Recommendation 4.13) Salaries paid to SIU investigators should be comparable to those paid to other investigators.
14. (Recommendation 4.14) The SIU should actively recruit civilian investigators with relevant experience who were not former police officers.
15. (Recommendation 4.15) At least 50 percent of the non-forensic investigators on an investigative team at the SIU should be investigators with no background in policing.
16. (Recommendation 4.16) The OIPRD should actively recruit civilian investigators with relevant experience who were not former police officers. No more than 25 percent of the OIPRD's investigators should be former police officers.
17. (Recommendation 4.17) The SIU and OIPRD should incorporate anti-bias measures into their recruitment, training, education, and evaluation of investigators.
18. (Recommendation 4.18) There should be a standardized education program to accredit SIU and OIPRD investigators.
19. (Recommendation 4.19) The required qualifications and accreditation of an oversight investigator should be set out in a regulation.
20. (Recommendation 4.20) The Ombudsman should have jurisdiction over all three police oversight bodies.
21. (Recommendation 5.1) "Serious injuries" should be defined in the legislation in accordance with the Osler definition.
22. (Recommendation 5.2) The mandate of the SIU should include all incidents involving the discharge of a firearm by a police officer at a person.
23. (Recommendation 5.3) The SIU should have the discretion to conduct an investigation into any criminal matter when such an investigation is in the public interest. When deciding whether an investigation is in the public interest, the SIU should consider the following:
  - i. if there is a request to investigate from a chief of police, a police services board, the Attorney General, or the Minister of Community Safety and Correctional Services;
  - ii. if the conduct in question involves allegations of criminal fraud, breach of trust, corruption, obstruction of justice, perjury, or another serious criminal offence; or
  - iii. if the matter is potentially aggravated by systemic racism or by discrimination.
24. (Recommendation 5.4) The SIU should have the discretion to lay charges for any criminal or provincial offence uncovered during an investigation.
25. (Recommendation 5.5) The SIU's mandate should include investigations of auxiliary members of a police force and special constables employed by a police force.

26. (Recommendation 5.6) The legislation should explicitly state that the SIU's mandate includes the investigation of former police officers and matters that pre-date the establishment of the SIU.
27. (Recommendation 5.7) The requirements for police notification of the SIU should be set out in legislation which should provide the following:
- The SIU must be notified of all incidents in which death or serious injury to a person may have resulted from the conduct of a police officer.
  - "Serious injuries" include any injury that is likely to interfere with the health or comfort of the victim and is more than merely transient or trifling in nature, including injuries resulting from sexual assault.
  - Without limiting the generality of the foregoing, serious injury will be presumed when the victim:
    - i. is admitted to hospital;
    - ii. suffers a fracture to a limb, rib, or vertebrae or the skull;
    - iii. suffers a dislocation;
    - iv. suffers burns to the body;
    - v. loses any portion of the body;
    - vi. suffers temporary or permanent loss of vision or hearing; or
    - vii. suffers serious soft tissue injuries.
  - The SIU must be notified of all incidents involving allegations of sexual assault against police officers.
  - The SIU must be notified of all incidents involving the discharge of a firearm by a police officer at another person.
  - Where a prolonged delay is likely before the seriousness of the injury can be assessed, the SIU must be notified so that it can monitor the situation and decide on the extent of its involvement.
28. (Recommendation 5.8) The general requirements of the duty to cooperate with the SIU, as well as the timing of that requirement, should be set out in the legislation. In particular, the legislation should stipulate the following:
- i. The duty to cooperate arises immediately upon SIU involvement; and
  - ii. The duty to cooperate requires the police to comply forthwith with directions and requests from the SIU.
29. (Recommendation 5.9) The general types of information or evidence that the SIU is normally entitled to receive, as well as any restrictions on the information or evidence the SIU can request, should be set out in the legislation.
30. (Recommendation 5.10) The legislation should clarify that "notes on the incident" means the duty notes written by a police officer during an SIU investigation.
31. (Recommendation 5.11) The legislation should explicitly specify that the duty to cooperate with the SIU applies to civilian members of a police force, special constables employed by a police force, and auxiliary members of a police force.
32. (Recommendation 5.12) The legislation should include a provincial offence for failing to cooperate with an SIU investigation punishable by fine, imprisonment, or both.
33. (Recommendation 5.13) SIU interviews of witness officers should be audio or video recorded unless, in the SIU's opinion, it would be impracticable to do so.

34. (Recommendation 5.14) The legislation should provide that the SIU may provide a copy of the record of a witness officer's interview to the witness officer if, in the SIU's opinion, it is appropriate to do so and on conditions that the SIU deems to be appropriate.
35. (Recommendation 5.15) A subject officer's notes on an incident prepared before SIU involvement should be produced to SIU investigators upon request.
36. (Recommendation 5.16) The Attorney General's directive granting immunity for subject officers' notes and statements in SIU prosecutions should be re-assessed in light of subsequent jurisprudential developments.
37. (Recommendation 6.1) At the end of an investigation, the SIU should release the name of a subject officer if the officer is charged.
38. (Recommendation 6.2) The names of witness officers should not be released.
39. (Recommendation 6.3) The names of civilian witnesses should not be released.
40. (Recommendation 6.4) The legislation should provide that the SIU reports to the public on every investigation.
41. (Recommendation 6.5) For cases where the SIU is notified but does not invoke or withdraws its mandate, the SIU should report in summary the reasons for its decisions as part of its annual report.
42. (Recommendation 6.6) For cases that result in a criminal charge, the SIU should release the following information:
  - i. the officer's name;
  - ii. the offence charged and date of charge; and
  - iii. details about the officer's next court appearance.
43. (Recommendation 6.7) For cases that do not result in a criminal charge, the SIU should release the director's report to the public.
44. (Recommendation 6.8) For cases that do not result in a criminal charge, the director's report should include the following elements:
  - an explanation why the incident falls under the SIU mandate;
  - a summary of the investigative process, including an investigative timeline;
  - a summary of the relevant evidence considered, including (i) physical evidence, (ii) forensic evidence, (iii) expert evidence, and (iv) witness evidence, which would include any evidence obtained from the subject officer;
  - any relevant video, audio, or photographic evidence of the incident in question, modified to the extent necessary to remove identifying information;
  - an explanation for why any of the evidence listed above was not included in the report;
  - a detailed narrative of the event;
  - the reasons for the director's decision, including (i) the reasons for preferring some evidence over other contradictory evidence, (ii) an explanation of any relevant legal standard, and (iii) an explanation why the conduct did not meet the standard for laying charges; and
  - a statement on whether the matter has been referred to the OIPRD as well as whether there were any issues with cooperation relating to the investigation.
45. (Recommendation 6.9) For cases that do not result in a criminal charge, the director's report should not include the following information:

- names of subject officers, witness officers, affected persons, or civilian witnesses (or any other evidence or information identifying them to the public);
  - any information that, in the discretion of the director, could lead to a risk of serious harm;
  - any information disclosing confidential police investigative techniques and procedures;
  - any information whose release is otherwise prohibited or restricted by law; and
  - any information that could identify a victim of sexual assault.
46. (Recommendation 6.10) For cases that do not result in a criminal charge, the director's report should be published online on the SIU website. Copies of the report should be provided to (i) the affected person or their next of kin, (ii) any subject officer, (iii) the chief of any involved police service, and (iv) the Attorney General.
47. (Recommendation 6.11) The legislation should be amended to allow the SIU to make public statements during an investigation when the statement is aimed at preserving public confidence, and the benefit of preserving public confidence clearly outweighs any detriment to the integrity of the investigation.
48. (Recommendation 6.12) The Attorney General should release past reports in the following circumstances:
- in all incidents in which a person died, prioritizing cases in which there was no coroner's inquest, subject to the privacy interests of the deceased's family;
  - in any incident on request of the affected person or, if the affected person is deceased, a family member of the affected person; and
  - on request of any individual when there is significant public interest in the incident reported on, subject to the privacy interests of the affected person or, if the affected person is deceased, the privacy interests of that person's family.
49. (Recommendation 6.13) Past reports should exclude the information set out in recommendation 6.9. Whenever possible, editorial notes should provide a summary of what the excluded information was about and an explanation for why it was necessary to remove it.
50. (Recommendation 6.14) The SIU should aim to conclude investigations, including any final reporting to the public, within 120 days. If the SIU has not concluded an investigation within 120 days, it should report to the public on the status of the investigation. The SIU should further report on the status of the investigation every 60 days thereafter, until the investigation has concluded.
51. (Recommendation 6.15) The Coroners Act should be amended to require that the coroner hold an inquest when a police officer's use of force, including use of restraint or use of a firearm, is a direct contributor to the death of an individual.
52. (Recommendation 6.16) The coroner should retain discretion to hold an inquest in cases where a police officer is involved in an individual's death, but that police officer's use of force was not a direct contributor to the death. For those cases, the coroner should provide written reasons to the public if the coroner decides not to hold an inquest.
53. (Recommendation 6.17) The government should provide funding for legal assistance to represent the interests of the spouse, parent, child, brother, sister, or personal representative of the deceased person at the coroner's inquest in SIU cases.
54. (Recommendation 7.1) The OIPRD should be renamed. The name should be easily understood and better reflect the OIPRD's core functions.

55. (Recommendation 7.2) The OIPRD should expand its public outreach program. The program should target both the general public and community organizations that serve vulnerable people.
56. (Recommendation 7.3) The complaint process should be easily accessible to all members of the public wherever they reside in Ontario.
57. (Recommendation 7.4) The OIPRD, together with community groups and organizations, should provide assistance to public complainants to help navigate the complaints process. This assistance should be offered from the initial intake through to final disposition of the complaint.
58. (Recommendation 7.5) Resources should be designated and made available to community groups and organizations to assist complainants through the complaints process.
59. (Recommendation 7.6) The OIPRD should receive and investigate public complaints concerning special constables employed by a police force and auxiliary members of a police force.
60. (Recommendation 7.7) A person should be prohibited from making a complaint if it appears that the person is acting as a proxy for a person otherwise prohibited from making a complaint.
61. (Recommendation 7.8) Police associations should be prohibited from making complaints regarding a police force or member of a police force within the jurisdiction of the police association.
62. (Recommendation 7.9) The Ministry of Community Safety and Correctional Services should review the process for members of a police service to make internal complaints to ensure there are effective whistleblower protections.
63. (Recommendation 7.10) A chief of police should be able to request that the OIPRD investigate a complaint, without the approval of the police services board.
64. (Recommendation 7.11) The OIPRD should have the discretion to conduct an investigation without a public complaint in any of the following circumstances:
  - if the SIU, a chief of police, or a police services board has referred a matter to the OIPRD for investigation;
  - if a public complaint has been made, and the OIPRD investigation reveals potential misconduct or policy or service issues other than those raised by the complaint itself;
  - if the complainant has withdrawn a complaint, but there is a public interest in continuing the investigation; or
  - if there is a public interest in initiating an investigation.
65. (Recommendation 7.12) Early resolution of complaints should be encouraged through the development and operation of alternative dispute resolution programs.
66. (Recommendation 7.13) The legislative grounds allowing the OIPRD to screen out complaints should be updated to reflect the fact that complaints are presumptively screened in, and that sufficient reasons need to be provided where they are screened out.
67. (Recommendation 7.14) The “public interest” ground for screening out complaints should be removed or, if retained, legislatively defined.
68. (Recommendation 7.15) The OIPRD should be given discretion to screen out complaints, or terminate the investigation of complaints, when investigation or further investigation is not necessary or reasonably practicable.

69. (Recommendation 7.16) Third party complainants should be allowed to file complaints. The OIPRD's discretionary grounds for not dealing with a third party complaint should be narrow.
70. (Recommendation 7.17) The OIPRD should have sole responsibility for screening complaints against a municipal chief of police or a municipal deputy chief of police, and should notify the police services board of its decision.
71. (Recommendation 7.18) The OIPRD should have sole responsibility for screening complaints made against the OPP Commissioner and OPP Deputy Commissioners and should notify the Minister of Community Safety and Correctional Services of its decision.
72. (Recommendation 7.19) The OIPRD should track complaints to identify officers who are the subject of multiple complaints and complainants who file multiple complaints without merit.
73. (Recommendation 7.20) Within five years, the OIPRD should be the sole body to investigate public conduct complaints.
74. (Recommendation 7.21) The OIPRD should receive funding and resources commensurate with its new responsibility to investigate all public conduct complaints.
75. (Recommendation 7.22) Over the next five years, until the OIPRD is able to conduct all public conduct complaint investigations, the OIPRD should be able to refer complaints to police forces for investigation. During this interim period, the OIPRD should be solely responsible for laying disciplinary charges and should have the authority to order further investigation or to take over an investigation conducted by a police force.
76. (Recommendation 7.23) The OIPRD should be solely responsible for investigating complaints against municipal chiefs of police, the OPP Commissioner, and their deputies.
77. (Recommendation 7.24) The OIPRD should have the discretion to retain service or policy complaints in appropriate circumstances.
78. (Recommendation 7.25) The OIPRD should be vested with the power to lay disciplinary charges against police officers.
79. (Recommendation 7.26) The "serious/not serious" and "substantiated/unsubstantiated" terminology for public complaints should be abolished.
80. (Recommendation 7.27) The general requirements of the duty to cooperate with the OIPRD, as well as the timing of that requirement, should be set out in the legislation. In particular, the legislation should stipulate the following:
  - i. The duty to cooperate arises immediately upon OIPRD involvement; and
  - ii. The duty to cooperate requires the police to comply forthwith with directions and requests from the OIPRD.
81. (Recommendation 7.28) The general types of information or evidence that the OIPRD is normally entitled to receive, as well as any restrictions on the information or evidence the OIPRD can request, should be set out in the legislation.
82. (Recommendation 7.29) The duty to cooperate with the OIPRD should specifically extend to civilian members of a police force, special constables employed by a police force, and auxiliary members of a police force.
83. (Recommendation 7.30) The legislation should include a provincial offence for failing to cooperate with the OIPRD punishable by fine, imprisonment, or both.
84. (Recommendation 7.31) The provincial government should request that the federal government amend the Youth Criminal Justice Act to permit the OIPRD to access records.

85. (Recommendation 7.32) The six-month limitation period for serving a notice of hearing for disciplinary matters should be eliminated for public complaints.
86. (Recommendation 7.33) Decisions of the OIPRD should be transparent to complainants, police officers who are the subject of a complaint, and police chiefs of the forces to which the complaint relates.
87. (Recommendation 7.34) The OIPRD should collect and publish summary information on the outcomes of all public complaints.
88. (Recommendation 7.35) The OIPRD should work towards performance metrics, reportable to the public, to ensure timely completion of its work.
89. (Recommendation 7.36) The OIPRD should communicate periodically with involved parties about the status of a complaint and inform them of its outcome as soon as is practicable.
90. (Recommendation 7.37) The OIPRD should make the results and recommendations of systemic reviews in the form of a written report. The report should be available to the public.
91. (Recommendation 7.38) The OIPRD should have the authority to designate in writing one or more chiefs of police to respond to recommendations from a systemic review. The designated chief of police or chiefs of police should be required to respond in writing to the OIPRD as soon as is feasible, but in any event within six months.
92. (Recommendation 7.39) The OIPRD should monitor complaints and publish the results of disciplinary charges, including the outcomes and penalties imposed.
93. (Recommendation 8.1) Independent public complaints prosecutors who work at the Ministry of the Attorney should prosecute public complaints. After the OIPRD lays a disciplinary charge, the independent public complaints prosecutor should be given carriage of the file.
94. (Recommendation 8.2) The OIPRD and public complainants should not have standing at disciplinary hearings, but may seek leave to intervene. Other interested parties also may seek leave to intervene.
95. (Recommendation 8.3) The OCPC should conduct all first instance hearings of public complaints.
96. (Recommendation 8.4) Internal complaints should be governed by the Police Services Act. Consideration should be given to what role, if any, the OCPC should have in the internal disciplinary process and how the internal and public disciplinary processes interact.
97. (Recommendation 8.5) Rights of review of a decision of the OCPC from a first instance hearing of a public complaint should be confined to the right of judicial review by the litigants in the Divisional Court.
98. (Recommendation 8.6) After the OIPRD lays a disciplinary charge, the independent public complaints prosecutor should have the power to settle the complaint.
99. (Recommendation 8.7) Prior to holding a disciplinary hearing, the OCPC should have the authority to direct that the parties engage in alternative dispute resolution.
100. (Recommendation 8.8) Disciplinary hearing decisions from the OCPC should be released as soon as practicable and made available to the public.
101. (Recommendation 9.1) The SIU investigation should take priority over all other investigations. When there is a parallel criminal investigation, a memorandum of understanding between the SIU and the police services should set out the mechanics of the

investigations. When there is a parallel civil investigation, the investigation should stand down at the discretion of the SIU.

102. (Recommendation 9.2) At the conclusion of the SIU's case, the SIU should deliver a copy of its investigative file to the OIPRD on request, subject to any privacy and confidentiality conditions.
103. (Recommendation 9.3) Section 11 reports should be made public, subject to the same considerations for SIU director's reports set out in recommendation 6.9.
104. (Recommendation 9.4) Police services should provide section 11 reports to the OIPRD for review. The OIPRD should have the discretion to publicly comment on a section 11 report and the authority to direct further investigation, require further explanation or amplification, and lay conduct charges.
105. (Recommendation 9.5) The requirement to commence a section 11 investigation "forthwith" should be eliminated. The section 11 investigation and report should be completed as soon as reasonably practicable.
106. (Recommendation 9.6) The legislation should authorize the SIU to comment on and refer conduct matters to the OIPRD and policy and service matters to the chief of police of the relevant force. Any cross-referral should be noted in the SIU's public report.
107. (Recommendation 9.7) The legislation should authorize the OIPRD to refer matters potentially falling within the SIU's jurisdiction to the SIU.
108. (Recommendation 9.8) In addition to conducting all first instance hearings from public complaints, the OCPC should adjudicate any other proceeding as directed by the Ministry of Community Safety and Correctional Services and the Ministry of the Attorney General.
109. (Recommendation 9.9) The OCPC's authority to approve the establishment, maintenance, and regulation of municipal detention facilities under section 16.1 of the Police Services Act should be eliminated.
110. (Recommendation 9.10) The OCPC's powers relating to the adequacy and standards of police services under sections 9, 23, and 24 of the Police Services Act should be eliminated.
111. (Recommendation 9.11) The OCPC's investigative, inquiry, and reporting powers under sections 25 and 26 of the Police Services Act should be eliminated.
112. (Recommendation 9.12) The OCPC's powers regarding budgetary disputes and the structure of police services under sections 5(1)(6), 6, 8, 9, and 40 of the Police Services Act should be eliminated.
113. (Recommendation 9.13) The OCPC's power to hear appeals from employees of a police force discharged or retired for becoming disabled under section 47 of the Police Services Act should be eliminated.
114. (Recommendation 9.14) The OCPC's appointment, suspension, and termination powers with respect to First Nations Constables under section 54 of the Police Services Act should be eliminated.
115. (Recommendation 9.15) The OCPC's power to direct internal complaints under section 78 of the Police Services Act should be eliminated.
116. (Recommendation 9.16) The OCPC's powers to conduct employment status hearings and approve the creation of different bargaining units under sections 116 and 118 of the Police Services Act should be eliminated.

117. (Recommendation 9.17) Requests to the OCPC for review of decisions concerning complaints relating to incidents which occurred before 2009 must be made to the OCPC within the next two years, after which time they can no longer be made.
118. (Recommendation 10.1) The oversight bodies should develop and deliver in partnership with Indigenous persons and communities mandatory Indigenous cultural competency training for their staff. This training should be a permanent and ongoing commitment within each organization, and include the following:
  1. A substantial course about Canada's Indigenous communities, with a focus on Ontario's Indigenous communities, including, but not limited to their history, culture, spirituality, language, and current issues. This training must be consistent, comprehensive, and available to all staff, especially those coming into contact or working with Indigenous peoples; and
  2. Key performance indicators to track outcomes and success.
119. (Recommendation 10.2) The oversight bodies should increase outreach to Indigenous communities and establish meaningful and equitable partnerships with Indigenous organizations.
120. (Recommendation 10.3) There should be ongoing recruitment and development of Indigenous persons at the oversight bodies, including in senior and leadership positions.
121. (Recommendation 10.4) The oversight bodies should implement a culturally-competent approach to service delivery.
122. (Recommendation 10.5) The oversight bodies should develop an ongoing audit process to assess the implementation and effectiveness of cultural competency and institutional change.
123. (Recommendation 10.6) Consideration should be given to expanding the mandates of the oversight bodies to include First Nations policing, subject to the opting in of individual First Nations.
124. (Recommendation 11.1) Ontario's police oversight bodies should collect demographic data on matters falling within their respective mandates. Relevant demographic data should include gender, age, race, religion, ethnicity, mental health status, disability, and Indigenous status.
125. (Recommendation 11.2) An advisory committee should be established to develop best practices on the collection, management, and analysis of relevant demographic data.
126. (Recommendation 12.1) The Ministry of Community Safety and Correctional Services should establish selection criteria for police services board appointees.
127. (Recommendation 12.2) The Ministry of Community Safety and Correctional Services should develop mandatory training for police services board members. This training should be developed in partnership with the Ontario Association of Police Services Boards and post-secondary institutions with expertise in the areas of public sector and not-for-profit governance.
128. (Recommendation 12.3) Consideration should be given to establishing a College of Policing similar to that in operation in England and Wales.
129. (Recommendation 12.4) Working with post-secondary institutions, a task force or advisory group should be created to evaluate, modernize, and renew police studies and law enforcement-related course offerings across post-secondary institutions. Consideration

should be given to updating the Ontario Police College curriculum, including through the creation of a post-secondary degree in policing.

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### **2.2.11 Halifax, Nova Scotia: Street Checks Report (Nova Scotia Human Rights Commission, 2019)<sup>145</sup>**

In the wake of public concerns about the role of race in police traffic stops in Halifax, the Nova Scotia Human Rights Commission commissioned this report by Dr. Scot Wortley of the University of Toronto's Centre for Criminology and Sociolegal Studies. Dr. Wortley consulted with members of Nova Scotia's Black community and police officials, conducted a community survey, conducted a literature review on racial profiling, police surveillance practices and police-community relations, and analysed "street check" data provided by the Halifax Regional Police.

Most participants in the consultations with members of the Black community considered "street checks" to include all situations in which police stop and question civilians, such as traffic stops or approaches on the street or in public places. Some participants were aware of the police practice of documenting encounters with civilians for intelligence purposes. They were concerned about the existence of this dataset, as it marks members of the Black community as "known to the police." Members of the Black community also reported a high frequency of involuntary contacts with police, either of themselves or of family and friends, and viewed them as random, arbitrary and unfair. They also reported stops of their young children and youth. Many identified racial bias or racial profiling as the cause of these stops. Participants also reported rude treatment by police during these stops, and reported open hostility and threats of arrest when they questioned the police about the grounds for these stops. They felt intimidated and complied with police directions out of fear of the consequences of non-compliance. Participants also noted that these unfair police stops of Black Nova Scotians had been happening for decades.

Black Nova Scotians said they were reluctant to report crime to the police or cooperate with investigations. They believed that the police would not investigate crime involving Black people, and worried that the police would then target the victim of the crime for harassment or arrest. Some participants reported positive interactions with police, and expressed appreciation for the difficulties involved in police work. However, few expressed any optimism that the situation would improve. Many participants also viewed the inquiry itself as a public relations exercise whose recommendations would be ignored. Older members of the Black community said they had seen many similar inquiries and reports, none of which had led to significant change.

Dr. Wortley and the Nova Scotia Human Rights Commission also conducted an internet-based community survey of Halifax residents in 2018. Most of the roughly 500 respondents were young or middle-aged white men. Black respondents had less trust and confidence in the local police than White respondents. Almost all Black respondents, and the majority of White respondents, believed that the police treat Black people worse than White people and that police racial profiling is a problem in the Halifax region. However, Black respondents were much more likely to believe that profiling is a "big problem" than White respondents. Black respondents, particularly men, were much more likely to report that they had recently been stopped and questioned by the police than White respondents. Black respondents were much more likely than White respondents to report that they themselves – and their family members and friends – had been victims of racial profiling by the police. Two-thirds of Black respondents reported that they had had at least one

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<sup>145</sup>"Street Checks Report" [https://humanrights.novascotia.ca/sites/default/files/editor-uploads/halifax\\_street\\_checks\\_report\\_march\\_2019\\_0.pdf](https://humanrights.novascotia.ca/sites/default/files/editor-uploads/halifax_street_checks_report_march_2019_0.pdf)

negative experience with the police, compared to only one-third of White respondents. The vast majority of both Black and White respondents believed that policing in the Halifax region can be improved. However, White respondents were more likely to defend the police against allegations of racial bias and suggest that police reform is unnecessary. As with the community consultations, some respondents expressed doubt that meaningful reform would take place in the near future.

Halifax Regional Police and RCMP officers and officials generally identified street checks as a specific intelligence-gathering event, in which police record information that may be relevant to future investigations or crime prevention. They said these checks can be helpful to identify potential suspects, locate missing persons, discover breaches of parole, probation or release conditions, identify people who may be a threat to officer safety in future, or clear individuals of suspicion. They can also identify whether a person applying to be a police officer has associations with known offenders. They often do not involve any direct communication, as officers will enter information they observe into the data system without speaking to the person they are observing. Many officers admitted that street checks can be “low quality”, due to poor training, little feedback from supervisors, and pressure to complete a certain number of street checks regardless of the quality or relevance of the information obtained. The officers explained the over-representation of Black people in street checks as reflecting the “reality” that Black people are more likely to be victims of violent crimes, and are more likely to live in poor, high-crime communities. Police therefore spend more time patrolling Black communities. Some of the officers acknowledged that racial stereotyping and unconscious bias on the part of some individual officers could contribute to the over-representation of Black people in street checks.

Participants in the police consultations agreed that Black civilians have less trust and confidence in the police than white civilians and agreed that at the least, there is a perception of racism and racial bias within law enforcement. Some denied that there was racism in law enforcement, and expressed fear of false allegations when interacting with members of the Black community. Some blamed police leadership for failing to explain the purpose of street checks. Others understood that frequent police checks of a Black civilian would lead to mistrust and resentment, and acknowledged that some officers do not communicate respectfully during these encounters. Some participants also stated that there is some racism within the police and that some officers do violate civil rights during street checks. However, they said they would be ostracized if they reported these incidents.

None of the officers recommended a ban on street checks. They did make recommendations to improve the quality of street checks, including removing incentives to conduct them. Officers also made many of the same recommendations as the survey respondents and Black community consultation participants, including increasing diversity within policing, screening recruits for racial bias, improving police communications, empowering officers to report unprofessional or illegal conduct on the part of their colleagues, and improving community policing and outreach. None of the officers made any recommendations about improving police oversight.

The report concluded with a statistical analysis of the frequency, targets and utility of street checks in Halifax. This analysis concluded that within the Halifax region, Black people, particularly young Black men, were grossly over-represented in police street check statistics. Although overall street check numbers had declined significantly in recent years, racial disparities had not diminished. Black individuals with no criminal record are twice as likely to experience a street check as whites with no criminal record, and Black individuals with extensive criminal charge histories are much more likely to experience multiple street checks than white individuals with similar records. Residential location does not appear to account for the over-representation of Blacks in police street check statistics. Racial disparities exist in all Halifax census tracts. There are more street

checks of Black people in predominantly white communities than there are in communities with a relatively high Black population. Dr. Wortley also concluded that there was very little evidence that street checks lower crime. Dr. Wortley also noted that over the previous decade, the number of Black men in Halifax who were charged with a crime was staggering – the equivalent of one third of the entire Black male population of the city.

Dr. Wortley was unable to determine what proportion of these racial disparities are caused by racial profiling rather than racially neutral police practices. He concluded that overt racism only explains a small proportion of these disparities, while unconscious racial bias can influence officers' beliefs as to who deserves police attention or appear to be suspicious. Officers also target the poor, the young, men, and members of racial minorities as being more likely to be involved in crimes. Police deployment practices can also have a disproportionate impact on Black communities. Dr. Wortley questioned whether racial differences in police practices, including street checks, contribute to the grossly disproportionate rates at which Black men are charged with crimes in Halifax. Given that street checks also erode trust in the police and have little effect on crime or public safety, he concluded that the costs of street checks are greater than the benefits.

Dr. Wortley made recommendations to enable either an outright ban on street checks, or new regulations and practices to reduce the potential for profiling and breaches of civil rights while maintaining the practice. He did not make a recommendation as to which of these options would be preferable.

Dr. Wortley briefly referred to concerns raised by consultation participants about the police complaints process, which he set out in the body of his recommendation on that issue.

The Halifax District RCMP published an interim report (undated) in response to the report setting out its efforts to meet the recommendations.<sup>146</sup> In October 2019, the Government of Nova Scotia issued an update on the implementation of the recommendations<sup>147</sup> and ultimately issued a directive banning all forms of street checks in the province.<sup>148</sup>

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

- [Assuming street checks are banned] A committee, consisting of both police officials and community members, should be formed to assess the impact of the street check ban on police-community relations and public safety. This committee should also explore the possible re-branding or re-naming of street checks or the shifting of street check information into other data fields (i.e., general occurrence reports).
- The HRP and RCMP should develop a protocol that will screen new recruits for both cultural competency and racial bias. The importance of this recommendation is reinforced by new research which suggests links between right-wing extremist groups and law enforcement and the possible infiltration of White supremacists into both policing and the military.

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<sup>146</sup>“Halifax District RCMP Interim Report on Recommendations in the Halifax, Nova Scotia: Street Checks Report” (undated) <https://www.rcmp-grc.gc.ca/en/ns/publications/halifax-district-rcmp-interim-report-recommendations-the-halifax-nova-scotia-street-checks-report>

<sup>147</sup> <https://novascotia.ca/just/publications/docs/Wortley-Report-Update.pdf>

<sup>148</sup>

<https://novascotia.ca/news/release/?id=20211202001#:~:text=The%20Province%20has%20strengthened%20the,is%20subjected%20to%20the%20practice.>

- The HRP and RCMP should continue to develop and implement mandatory anti-bias, cultural competency and race relations training.
- The HRP and RCMP should continue to develop and implement training modules designed to educate police officials about local Black history and the contemporary social and law enforcement concerns of the Black community. These modules should be delivered, on-site, by Black community members. Such efforts will give members of the Black Nova Scotian community a stake in police training strategies and could help build mutual understanding, empathy and compassion.
- Although mandatory, a potential weakness with current anti-bias training strategies is the lack of officer performance evaluation. In other words, officers only have to “take” these training courses, they do not have to “pass” them. Anti-bias training can, therefore, be viewed as a box that must be ticked rather than a skill-set or knowledge-base that must be learned. Thus, it is recommended that the HRP and RCMP develop a testing or evaluation strategy for all anti-bias, cultural competency or race relations courses. Such a testing strategy will ensure that officers take these training opportunities seriously and increase the likelihood that teaching objectives will be met.
- It is recommended that both the HRP and RCMP continue to hire police officers from diverse backgrounds and that police services continue to reflect the racial/ethnic makeup of the communities they serve. It is recognized that the Halifax Regional Police is already more racially diverse than the population it serves. This trend should be both celebrated and continued.
- It is recommended that Black and other minority officers be promoted to positions of upper management within both the HRP and Halifax region RCMP. Both community members and police participants maintained that minority officers must be promoted to upper management before they can have a positive impact on police culture and police practices. It was suggested that appointments to the police executive would also have great symbolic value and could contribute to an improve police-community relationship.
- It is recommended that both the HRP and RCMP devote more time and resources to community policing efforts. Both community members and police officials stressed that the police should get to know better the people they are policing, and that the community should get the chance to know the police. It was stressed that this could be accomplished if officers were stationed in the same communities for sustained periods of time (i.e., several years). It is also recommended that the police, in conjunction with community leaders, organize more social opportunities in which community members and police officers can interact and learn about each other. Individual police officers are also encouraged to participate, off duty, in community activities (i.e., church, sports events, festivals, etc.) so that they could develop relationships with community members. Such participation will likely send a positive message to community members and “humanize” the police profession.
- It is recommended that the police establish more community-level detachments like the one recently developed in North Preston. Such local detachments should operate seven days a week, twenty-four hours a day. In the absence of local detachments, it is recommended that both the HRP and RCMP deploy more community liaison officers to cultivate local relationships, develop local knowledge and act as mediators between the community and regular patrol officers.
- It is recommended that a committee – consisting of community members, police officials and government stakeholders – be formed to study the strength and integrity of the current police complaints process. Both the HRP (Police Complaints Commission) and the RCMP

(Commission for Public Complaints) have independent police complaints bodies. However, during consultations, community members expressed serious doubts about these organizations.

Community concerns included:

1. A lack of community awareness about how to file a complaint;
2. The inability to file verbal complaints;
3. The inability to file 3rd party complaints;
4. The six-month time period for filing;
5. A lack of independent complaint investigation and adjudication (i.e., the fact that complaints are returned to the police service in question for internal investigation, deliberation and disciplinary decisions);
6. A lack of transparency with respect to the investigative process and the rationale behind complaint decisions, and
7. A confusing, convoluted appeals process.

Some community members expressed that they had previously filed a complaint against the police and found the process to be confusing, frustrating and unfairly biased in favour of the police. All stated that, as a result, they would never file a complaint against the police again. The proposed committee should examine these issues and make recommendations for improving the current police complaints system and increasing community confidence in the complaints process.

As part of the police oversight process, the government should also consider creating and funding an African Nova Scotian Legal Advocate or Legal Clinic. Such an organization would help Black youth and adults negotiate the police complaints process and provide them with legal advice on other criminal justice matters. The creation of such a body might also serve to increase confidence in the overall criminal justice system.

- It is recommended that the HRP and RCMP develop additional training modules that will improve officer adherence to the principles of procedural justice and ensure respect for civil rights during all civilian encounters. Such training should focus on developing officer communication skills and their ability to explain lawful police actions to civilian actors.
- It is recommended that the HRP and RCMP develop new policies to address the police code of silence and empower officers who challenge the illegal or unprofessional activities of their colleagues. Officers should receive continual training with respect for both existing and emerging departmental regulations. Punishment for the violation of these regulations should be clearly communicated and consistently enforced.
- It is recommended that the HRP and RCMP develop a new performance evaluation system that explicitly rewards officers for their community policing efforts, their ability to work effectively with diverse communities and their ability to develop relationships of trust with community members from various backgrounds. Performance indicators should be clearly articulated and communicated to all police officers and further entrenched in the promotion process.
- It is recommended that the HRP and RCMP fully engage in efforts to evaluate the effectiveness of all anti-bias initiatives and community building strategies – including anti-bias training and community policing protocols. Evaluation should take the form of continued data collection on street checks and other policing outcomes. Changes with respect to public trust and confidence in the police should be monitored through ongoing community consultations and periodic surveys. The police should engage with objective, outside experts to develop

evaluation methodologies and analytic strategies. The results of evaluation projects should be fully disseminated to the public.

- It is recommended that a committee – consisting of community members, police officials and government officials – be formed to monitor progress towards the implementation of the recommendations produced by this report, or additional policy initiatives that emerge post-release. This committee should report to the Police Board of Commissioners by September 2020.
- Finally, it is recommended that the Government of Nova Scotia, and the Nova Scotia Human Rights Commission, extend their examination of racial bias beyond police street checks to other aspects of policing and the broader criminal justice system. Statistics reveal that Black Nova Scotians are significantly over-represented in both the provincial and federal correctional systems. It is important to determine the extent to which this over-representation reflects possible biases at each stage of the criminal justice process: from police surveillance and charge practices to remand decisions, plea bargaining, conviction rates, sentencing and parole outcomes. A small degree of racial bias at each stage of the criminal justice funnel can result in gross racial disparities within the correctional system. This inquiry could begin by mandating the collection of race-based statistics within policing, the criminal courts and corrections.

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### **2.2.12. Independent Review of the Manitoba Police Services Act (2020)<sup>149</sup>**

This review was conducted in accordance with the provisions of Manitoba's Police Services Act (2009), which requires that the Minister of Justice undertake a comprehensive review of the Act within five years of its enactment. The Minister of Justice retained the Community Safety Knowledge Alliance to conduct the review. The review explored whether the Police Services Act (PSA) supports the delivery of police services in a professional, transparent, and effective manner; and considered whether amendments should be made. The review conducted a literature and documentation review, focusing on the context of policing; an analysis of the Act and regulations and comparisons with legislation and police oversight in several other provinces; stakeholder consultations; and qualitative and quantitative data analyses.

The Report identified increasingly complex and interconnected trends in the context of Canadian policing, including the changing nature of crime, emerging technologies, increasing complexity of criminal investigations, a move toward multidisciplinary collaborative approaches to community safety, and escalating police costs. It also noted that calls for improved police accountability, responsiveness, and transparency are magnifying longstanding social justice and equity problems in Canada, including economic disparities, mental health, and addictions, gender-based violence, racial discrimination, and the overrepresentation of Indigenous people in the justice system.

The Report identified the expanding role of communities and other actors in providing for their own safety. Crime-prevention strategies involving community and inter-agency collaboration are now preferable for forward-looking policymakers.

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<sup>149</sup> "Final Report: Independent Review of the Manitoba *Police Services Act* (2009)." Community Safety Knowledge Alliance (September 2020), [https://www.manitoba.ca/asset\\_library/en/proactive/2020\\_2021/Independent-Review-Manitoba-Police-Services-Act-Sept2020.pdf](https://www.manitoba.ca/asset_library/en/proactive/2020_2021/Independent-Review-Manitoba-Police-Services-Act-Sept2020.pdf).

Increasingly, policing services and community safety are no longer the purview of isolated institutions; they have instead become part of a wider network of government services, community groups, and non-profit and private organizations, often involved directly in crime prevention and local safety initiatives.<sup>150</sup>

The Report discussed the differences in urban and rural policing, as well as the differences in crime in urban and rural areas. Rural crime rates are 30% higher than urban crime rates across Canada, and higher still in the prairies. Indigenous people are also disproportionately likely to be homicide victims and to be accused of murder. Costs of policing are rising. Manitoba residents are significantly less likely than residents of other parts of Canada to state that police are effective at ensuring the safety of residents, responding promptly to calls, treating people fairly, or enforcing laws. They are also less likely to have confidence in the RCMP or their local municipal force than other Canadians. Members of Indigenous and visible minority communities have less confidence in police than other parts of the population. Manitoba also has a very high rate of Criminal Code incidents per officer compared to other Canadian jurisdictions. The associated workload may prevent officers from engaging in crime prevention efforts. The Report emphasized the need for police to be structured and organized so as to be able to respond and adapt to change and challenges, as illustrated by the recent demands on policing of the COVID-19 pandemic.

The Report noted the significant effect that policies and legislation enacted by governments have on policing reform. The Reviewers cited a 2018 study which found that political cycles are key drivers of change in policing and which identified “the typical four-year political cycles where decisions made by these governments can impact the operations of the police, courts, and corrections for generations unless overturned by the next government” as a key challenge.<sup>151</sup> The Report also identified a number of barriers to change in police agencies, including workplace demographic factors, resource limitations, organizational culture and inertia, resistance to change, inadequate police leadership, and police associations. The Report identified the following additional obstacles to police reforms:

Many police reforms fail because they were not properly conceptualized or communicated, were inadequately funded or supported, or were poorly implemented (Schafer & Verano, 2017). Some reforms are based on ideas developed by civilians that do not account for the nature of police work or organizational culture (Skogan, 2008). Other changes are launched by politicians who lose interest in supporting these reforms several years after their introduction, and these reforms flounder.

As a result, some police leaders are reluctant to engage in changes, which leads to organizational inertia. Canadian research has found that organizational inertia and resistance to change were among the most significant barriers to reforms identified by police officers and agency stakeholders (Duxbury et al., 2018).

One reason why there is such a history of failed changes is the lack of a clear vision for the future of policing, although many academics and police contend that policing needs to be reimagined, reinvented, or transformed (Gascon & Fogelson, 2010; Lum & Nagin, 2017; Millie & Bullock, 2012). For example, a growing number of scholars and policymakers believe the police need to engage more in partnerships in order to respond to the

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<sup>150</sup> “Final Report: Independent Review of the Manitoba PSA,” p. 3.

<sup>151</sup> “Final Report: Independent Review of the Manitoba PSA,” p. 33, citing L. Duxbury, C. Bennell, M. Halinski, & S. Murphy. (2018) “Change or Be Changed: Diagnosing the Readiness to Change in the Canadian Police Sector” *Police Journal: Theory, Practice and Principles* 91(4): 316–38.

entrenched social problems that are the source for individuals and families at risk of harm or engaging in crime.<sup>152</sup>

The Report noted that one form of community partnership, the “hub” model of co-location and collaboration of services<sup>153</sup>, was well entrenched in Manitoba as well as in other parts of Canada.

The Manitoba Police Services Act was enacted in 2009 partly in response to an inquiry into the police-involved death of Crystal Taman and the subsequent investigation.<sup>154</sup> The new Act, which replaced legislation in place since 1987, was intended to modernize police governance and oversight. It established the Manitoba Police Commission, municipal and First Nations police boards, and the Independent Investigation Unit (IIU). After reviewing the legislative framework for policing in Ontario, British Columbia, and Saskatchewan, the Independent Reviewers considered the feedback from their consultations as to the effectiveness of the Police Services Act. Although it was generally seen as a significant improvement on the old legislation, the Reviewers identified the following areas for improvement:

Under the PSA, the minister is responsible for ensuring “adequate and effective policing” in the province. That standard of “adequate and effective policing” is also the standard that police services, police boards, and policing standards must meet. The Director of Policing, who acts under the general direction of the minister, is responsible for the oversight and supervision of police services and coordinating policing across Manitoba. The Director may also issue standards, directives, or guidelines to promote “adequate and effective policing.” However, the term “adequate and effective policing” was not defined in the Act or its regulations. This made it difficult to establish standards. Indigenous stakeholders also raised concerns about the ambiguity and lack of relevance of the term in their communities. Other jurisdictions used the same term but provided more specific definitions.

The Report identified serious deficiencies in the development of police standards under the PSA. The existing standards were outdated, and there were no standards relating to evidence and disclosure, police equipment, use of force, critical incidents and emergency response teams, police pursuits, major case management, and training. The report stated:

The importance of creating a fulsome and comprehensive legislative and standards framework cannot be overstated. An effective structure will support and promote the delivery of adequate and effective policing; reduce overall risks, including unnecessary litigation; and enhance public trust in the police. An effective standards framework will also contribute to improving police legitimacy and help police services adapt to an increasingly complex operating environment.<sup>155</sup>

The Report noted that New Brunswick and Alberta had comprehensive and up-to-date policing standards, which were also easy to use.

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<sup>152</sup> “Final Report: Independent Review of the Manitoba PSA,” p. 34.

<sup>153</sup> For more information on hub models in the policing context, see <https://www.publicsafety.gc.ca/cnt/cntrng-crm/crm-prvntn/nvnt/dtls-en.aspx?i=10015>

<sup>154</sup> Crystal Taman was a 40-year-old mother of three who was killed in Winnipeg when her car was hit by a truck driven by an off-duty police officer. The officer was charged with several offences, including impaired driving causing death. The Crown’s agreement to a guilty plea to dangerous driving causing death, and a mild sentence, led to an inquiry. See “Taman Inquiry into the Investigation and Prosecution of Derek Harvey-Zenk” (2008), <http://www.tamaninquiry.ca>.

<sup>155</sup> “Final Report: Independent Review of the Manitoba PSA,” p. 53.

There was also no uniform code of conduct for municipal officers. The provisions of the Act providing for compliance inspection had also not been enacted. The role of the Manitoba Police Commission (MPC), which is designed to provide advice to the minister on regulations, including prescribing standards for police services and officers, was also unclear. Its budget and signing authority were directly controlled by the ministry, limiting its independence. Its advice on modernizing standards and regulations had been largely ignored. Stakeholders suggested that the MPC should have an independent inspection or audit function for police boards.

The establishment of police boards under the Act was seen as a positive development, although there was some concern about conflict between the police service and police board, or between the police board and municipal council. Municipal councils designate the chair and vice chair of the police board and can revoke the appointments of chairs and council members on the boards at any time, raising concerns about the boards' independence from councils. The boards' actual power was seen as limited, as was their ability to create community safety plans. The Report noted that stakeholders identified Ontario's recent requirement that municipalities develop community safety plans as a positive development and "repeatedly pointed to the evolving nature of threats to community safety and the important role that more strategic and collective plans can play in addressing such risks."<sup>156</sup> Municipal stakeholders, in contrast, thought that police boards should be abolished or at least not be mandatory.

Police service delivery resources were over-extended, particularly in rural communities facing methamphetamine problems. Although RCMP delivery was outside the scope of the Report's work, the Reviewers noted that stakeholders in communities where police services were provided by the RCMP believed that constrained resources within the RCMP had an adverse effect on the sense of safety in their communities. They also raised concerns that the recent shift in the RCMP policing model, whereby resources were centralized, would lead to greater problems with police coverage and response time. The development of alternative community safety resources was therefore a major concern. Funding models for policing did not address rising policing and community safety costs. Stakeholders, particularly municipalities, identified a number of alternative forms of service delivery that could relieve the pressure on police. First Nations Safety Officers were in place in First Nations communities. Community Safety Officers had been established in one municipality, Thompson, and had authority to assist police in noncriminal matters such as implementing crime prevention initiatives, connecting social service providers with members of the public in need of their assistance, and maintaining community presence. The Report recommended that they be permitted to assist in criminal matters that did not involve enforcement, such as guarding crime scenes. The Report also recommended that Manitoba adopt a program similar to Alberta's Peace Officer Program, which allows the provincial government and municipalities to employ peace officers for a range of duties including highway traffic enforcement, prisoner transport, fraud investigations, school security, bylaw enforcement, nonurgent calls for service, property damage, assisting police investigations, and conflict resolution. They are subject to provincial standards and training and have distinctive uniforms and vehicle markings. Their salaries are significantly lower than those of sworn police officers. The Report also recommended that municipalities be required to incorporate Community Safety and Well-Being Planning for inter-agency cooperation to reduce risk and harm, as had been successfully implemented in other jurisdictions.

Although the PSA confirms First Nations policing arrangements and includes provisions for community safety resources such as First Nation Safety Officers, the PSA does not directly affect

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<sup>156</sup> "Final Report: Independent Review of the Manitoba PSA," p. 42.

policing in Indigenous communities. The only First Nation police service in the province operates with its own legislative and regulatory framework. The MPC is required under the Act to have a Métis member, but the Act does not require Métis involvement in any other institution or body responsible for police oversight such as police boards. There was a strong view among stakeholders that there should be more Indigenous representation on police oversight bodies. Stakeholders raised concerns about the rigidity and complexity of funding models for First Nations policing. Those models made it difficult to launch new community safety programs or plan and pay for critical infrastructure and capital programs. First Nations Safety Officers are critical to ensure the safety of First Nations communities, particularly in the north, but are not adequately funded. They have no clear governance or oversight structure, which is particularly problematic given that their training and equipment allow them to use force and potentially harm a member of the public. They are often required to stretch the limits of their authorities, given the absence of other policing resources in northern and remote communities. They were given increased authority to respond to COVID-19-related directives, such as enforcing physical distancing guidelines.

The Law Enforcement Review Agency (LERA), which handles public complaints about police, was considered by most stakeholders to be ineffective. It was thought to place a disproportionate burden on complainants, could not initiate investigations in the public interest or arising from patterns in complaints, and is underfunded and understaffed. LERA itself had consistently called for changes to its legislation over the previous eight years to address what it identified as a significant advantage to officers, including the facts that complainants rarely had counsel, while officers were represented; officers are not compellable; the standard of proof was “clear and convincing evidence,” which was too high a standard; and complaints had to be filed within 30 days of an incident rather than the usual six to twelve months. The number of findings against officers was extremely low in proportion to the number of complaints filed.

The Report recommended the development of dispute resolution mechanisms for police complaints through a diversity and inclusivity lens, noting that the majority of structures for addressing allegations of misconduct by police in Canada are colonial and bureaucratic. Mechanisms similar to those used in Indigenous communities, such as healing circles and peacemaker courts, might engage more members of those communities to engage with the complaints process.

The Independent Investigation Unit was generally considered effective. However, there was confusion about the officers’ duties to cooperate, the distinction between “subject” and “witness” officers, and the designation of officers’ notes and reports. Stakeholders also noted the need for continuing public education about the IIU mandate and independence. The Report recommended that the IIU be governed by a separate act in order to reinforce its independence from the police, citing Justice Tulloch’s recommendation to that effect in Ontario (summarized at section 2.25, above). It also recommended amendments to clarify an officer’s duty to cooperate in order to allow the IIU impose sanctions on officers who failed to comply and to allow the minister to broaden the IIU mandate to include other peace officers.<sup>157</sup> It also recommended requiring chiefs to inform the IIU when it suspects that an officer may have broken the law. The Reviewers stated that they had no view as to whether allegations of intimate partner violence or sexual assault should be included within the IIU mandate. Following Justice Tulloch, the Reviewers recommended that former police officers continue to be allowed to work as investigators, but

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<sup>157</sup> The Report noted that the duty to cooperate for witness officers had been clarified by a recent decision of the British Columbia Court of Appeal: *Independent Investigations Office of British Columbia v Vancouver (City) Police Department*, 2020 BCCA 4 (CanLII), <https://canlii.ca/t/j4c9b>, retrieved on 2022-02-14.

current officers should be prohibited from being seconded to investigate. The Report recommended recruitment of more civilian investigators and investigators from diverse backgrounds, particularly Indigenous backgrounds.

In cases where an officer may have caused the death of a person, the PSA required the IIU civilian director to appoint a civilian monitor to monitor the IIU investigation. The director had the discretion to appoint a civilian monitor in other cases. Manitoba is the only province to require these civilian monitors. The civilians who had been appointed to date were all in a civil service internship program for future managers, and none had a background in investigations. There had been no Indigenous monitors. There was no evidence that these monitors, even if properly qualified, could significantly improve the oversight provided by the IIU. The Report therefore recommended that the civilian monitor program be abolished. Instead, it recommended that the civilian director be able to appoint a community liaison or observer to work with the investigation unit during an investigation.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

- (Recommendation 1) That Manitoba Justice adopt accountability frameworks for both police personnel and police organizations, whereby the Director of Policing is responsible for defining and issuing expectations; and independent agencies (e.g., LERA, IIU, and MPC) are responsible for verifying the maintenance of such expectations.
- (Recommendation 2) That Manitoba Justice establish in regulation how it defines and will measure adequate and effective policing. It is further recommended that in doing so, Manitoba Justice adopts the language utilized by both Alberta and New Brunswick, with the only variation being the inclusion of a clause pertaining to the adherence to the Canadian Charter of Rights and Freedoms and the Manitoba Human Rights Code.
- (Recommendation 3) That, using regulations as sparingly as possible, Manitoba Justice develop a consolidated policing standards framework that is based on the Alberta and New Brunswick models and that contains content similar to those models.
- (Recommendation 4) That a risk-based approach be taken to develop policing standards, with priority for immediate development given to:
  1. use of force and arrest;
  2. investigations (major case management);
  3. disclosure of evidence;
  4. critical incident response;
  5. motor vehicle pursuits;
  6. intimate partner violence investigations; and
  7. missing persons (aligned, as appropriate, to the report on the National Inquiry into Missing and Murdered Indigenous Women and Girls).
- (Recommendation 5) That the Ministry of Justice develop a Major Case Management regulation that defines what constitutes a “major case” and that establishes the foundation for the local development of related policies by police boards, from which police chiefs can develop internal policies and procedures.
- (Recommendation 6) That the Ministry of Justice develop a provincial Major Case Management manual, using the Ontario and RCMP manuals for useful and appropriate comparison.

- (Recommendation 7) That appropriate standards regarding the disclosure of evidence be incorporated into the Major Case Management standard.
- (Recommendation 8) That Manitoba Justice should, as a matter of priority and within a broader Policing Standards framework, develop a critical incident response standard.
- (Recommendation 9) That the government consider designating the Manitoba Police Commission as an Independent Office of the Legislative Assembly.
- (Recommendation 10) That the Manitoba Police Commission be authorized to manage its own finances once that budget is approved.
- (Recommendation 11) That the Manitoba Police Commission be assigned the additional duties of auditing police services' and police boards' compliance with standards that are developed by the Director of Policing.
- (Recommendation 12) That municipal police boards continue to be mandatory.
- (Recommendation 13) That the Police Services Act clarify the importance of police board independence in their relationships with municipal councils and establish a budget dispute arbitrator such as the Manitoba Police Commission.
- (Recommendation 14) That the Police Services Act be amended to replace two municipal appointees with two provincial appointees.
- (Recommendation 15) That the Police Services Act be amended to provide that permissible reasons for early termination of police board appointments be restricted to: (1) voluntary departure, (2) incapacitation, or (3) serious violation of the Board Member Code of Conduct prescribed in regulations.
- (Recommendation 16) That before a person is appointed to a municipal police board, the appointing authority consider the results of the potential appointee's recent police record check and that the record check be conducted by an agency other than the police service governed by the board for which that person is being considered.
- (Recommendation 17) That the legislated responsibilities of police boards include:
  1. the provision of policing in the jurisdiction;
  2. the overall adequacy and effectiveness of policing; and
  3. establishing strategic plans for policing in the jurisdiction, taking into account provincial policing priorities and local community safety and well-being plans.
- (Recommendation 18) That the police board's duty to "act as a liaison between the community and the police service" be removed from legislation and discontinued.
- (Recommendation 19) That police boards become the employer of their police chiefs and all sworn and civilian police employees and be responsible to direct and oversee collective bargaining undertaken by agents on their behalf.
- (Recommendation 20) That police governance performance standards be developed by the Director of Policing and articulated in regulations.
- (Recommendation 21) That all board members be required to complete training on their responsibilities prior to voting in a board meeting. Also, as a condition of remaining on the board, that board members complete further training on strategic planning, policy development, performance evaluation of police chiefs and police programs, establishing a mandate of collective bargaining, and financial planning within the first 2 years of their appointment.

- (Recommendation 22) That the Manitoba Police Commission develop and implement a risk-based inspection system of police boards performance relative to performance standards and direct corrective police board action where and when it is needed.
- (Recommendation 23) That the Police Services Act be amended to incorporate Community Safety and Well-Being Planning as a mandatory requirement for municipalities.
- (Recommendation 24) That police board policies be revised to specifically state the requirement to have a board composition that is reflective of the wider community and which specifically encourages the membership of representatives of First Nations, Métis, and newcomer communities.
- (Recommendation 25) Given the prominence of Métis communities in the history of Manitoba, that Métis representation on and engagement with policing governance and oversight bodies be encouraged
- (Recommendation 26) That Manitoba Justice adopt a layered model for policing in Manitoba and engage key stakeholders in refining some of the particular details of the model.
- (Recommendation 27) That in order to better align CSO and FNSO authorities, Section 77.6 be amended to read: "...Community Safety Officers may provide general assistance to the local policing authority when requested to do so by a member of the local police authority, as long as the assistance does not involve any criminal law enforcement activities."
- (Recommendation 28) That the Government of Manitoba adapt the Alberta Peace Officer model to the Manitoba context and that authorities within each level should be granted based on the needs of the community or hiring organization.
- (Recommendation 29) That the Manitoba Peace Officer Program be established through its own legislation—The Peace Officer Act—and corresponding regulations.
- (Recommendation 30) That the Manitoba Peace Officer Program encompass all current peace officers appointed under various provincial legislation.
- (Recommendation 31) That Level 1 MPOs be employed only through the Ministry of Justice and Manitoba Infrastructure (as pertaining to motor carrier enforcement and investigations) to complement the work of the police in:
  1. ensuring safe roadways throughout Manitoba;
  2. providing prisoner transport and courthouse security; and enforcing such provincial statutes and sections of the Criminal Code pertinent to their mandates.
- (Recommendation 32) That other government ministries' investigative and enforcement personnel fall under the MPO Level 2 categorization.
- (Recommendation 33) That the Community Safety Officer, First Nation Safety Officer, and Institutional Safety Officer programs, together with any other public-facing non-bylaw enforcement peace officers employed by municipalities or First Nations, fall under the new Community Peace Officer Level 1 designation, thereby ensuring symmetry in programming, standards, and compliance.
- (Recommendation 34) That the ministry work closely with municipalities, First Nations, and the police boards and police services of jurisdictions to determine the appropriate balance of enforcement responsibilities between the police and Level 1 CPOs in such jurisdictions.
- (Recommendation 35) That in order to ensure role clarity, joint planning, and mutually reinforcing deployment strategies, standards in both the Police Services Act and the proposed Peace Officer Act establish the requirement for the creation of memoranda of understanding

to address such matters as information-sharing, communications, joint planning, and coordination of enforcement activities.

- (Recommendation 36) That Level 2 CPOs comprise such functions as parking enforcement officers, police exhibit custodians, and animal control specialists.
- (Recommendation 37) That a set of standards governing the use of force (with a strong emphasis on de-escalation) be developed to apply to all levels of MPO/CPOs and that align with the use of force standards in place for the police.
- (Recommendation 38) That Part 8 (Special Constables) of the Police Services Act be repealed.
- (Recommendation 39) That the government adopt more contemporary language in the legislation to describe the responsibilities of police chiefs with regards to conduct and discipline. As one example, section 22(1) (c) of the PSA should be amended to read, “the maintenance of police professionalism.”
- (Recommendation 40) That Manitoba Justice draft a new Oath of Allegiance that will apply to all municipal police officers and peace officers to follow, and to display it prominently in legislation.
- (Recommendation 41) That Manitoba Justice develop a uniform Code of Conduct based on existing models, such as the RCMP model, that will apply to all municipal police officers in Manitoba.
- (Recommendation 42) That Manitoba Justice also develop a Code of Conduct that applies to all peace officers in Manitoba.
- (Recommendation 43) That the government define levels of misconduct and thresholds between minor and major misconduct either in legislation or subsequent regulations, such as a uniform Code of Conduct.
- (Recommendation 44) That LERA legislation remains separate from the Police Services Act and that, as a first step, the government consider LERA’s internal analysis as a guide to how its legislation might be amended (at least in the short term) in order to make the public complaint system more efficient and equitable.
- (Recommendation 45) That Manitoba Justice develop language and guidance for chiefs of police to establish flexible and responsive dispute resolution mechanisms that bring diverse and marginalized communities into the process to address allegations of police misconduct and to address and repair harm in the relationship with those communities. The government should also offer chiefs of police the opportunity to resolve less serious allegations with more appropriate means of dispute resolution.
- (Recommendation 46) That the government adopt prescriptive time requirements similar to those proposed by the Supreme Court of Canada in *R v Jordan* (2016), for the meaningful conclusion of investigations of allegations of misconduct.
- (Recommendation 47) All public complaints be reported to LERA in real time, including their complaint type, disposition, and resolution. LERA should report the aggregate public complaints data to the government and to the people of Manitoba annually.
- (Recommendation 48) That the government embed the requirement for chiefs of police to establish workplace harassment programs. Where appropriate, these should serve to thoroughly and safely address workplace harassment concerns outside the police misconduct system.

- (Recommendation 49) That there be separate legislation to govern the Independent Investigations Unit.
- (Recommendation 50) That the Act be amended to provide specific direction concerning the requirement for police chiefs, police services, and police officers to comply with all reasonable requests made by the IIU director or investigators.
- (Recommendation 51) That legislation pertaining to the IIU be amended to provide for the sanctioning of those who fail to meet the duty to comply with IIU investigations.
- (Recommendation 52) That legislation be amended such that the minister may designate any class or individual peace officer to fall under the relevant provisions compelling their cooperation with the IIU.
- (Recommendation 53) That the IIU Regulation be amended as follows:
  - 12(1) An investigator may make a written request to a police chief to interview a police officer. The request must set out the time and location of the interview.
  - 12(2) A subject officer is not required to be interviewed by an investigator, but the officer may voluntarily agree to be interviewed.
  - 12(3) Subject to subsection (4), an interview with a witness officer must take place at the time and location specified in the request.
  - 12(4) In response to a written request from the police chief, the civilian director may, by written notice, grant the requested postponement of an interview or refuse to postpone an interview.
  - 12(5) The police chief must ensure that the witness officer attends an interview as required by this section.
- (Recommendation 54) That the Act be amended to provide that the civilian director, in consultation with the director of public prosecutions, may designate a Crown attorney to act as the acting director while the director is absent or otherwise unable to perform the duties of his or her office.
- (Recommendation 55) That section 73(1)(b) be revised so that a police chief must immediately notify the IIU when a police service has any suspicion or is conducting an investigation into the conduct of a police officer and where there is evidence that the officer may have contravened the Criminal Code or any other federal or provincial enactment, other than the provisions prescribed under clause 65(1)(c).
- (Recommendation 56) That Part 7, Division 3 of the Act be amended to also apply to off-duty officers.
- (Recommendation 57) That the term “immediately” be used in Sections 66(1), 66(2), and 73(1).
- (Recommendation 58) That the term “formal complaint” be replaced by “complaint” in sections 66(2) and 73(1).
- (Recommendation 59) That the definitions of “incident notes” and “record” be included in the PSA or in the IIU regulations.
- (Recommendation 60) That the PSA includes a duty for officers to complete their incident notes as soon as possible with respect to an IIU incident.
- (Recommendation 61) That public safety reports no longer be required and that Sections 8(1) and 8(2) be repealed.

- (Recommendation 62) That the definition of “serious injury” be expanded to include fractures to the clavicle, pelvis, and hip, and any injury that requires admission to a hospital or health care facility on an in-patient basis.
- (Recommendation 63) That the IIU continue to allow former police officers to work as investigators but be encouraged to continue to recruit investigators who do not have a police background. The secondment of serving police officers to the IIU should be discontinued.
- (Recommendation 64) That the IIU be encouraged to recruit investigators from diverse backgrounds with a particular emphasis on people with Indigenous backgrounds.
- (Recommendation 65) That Manitoba Justice terminate the Civilian Monitor Program.
- (Recommendation 66) Should the CMP be retained, that:
  1. Civilian monitors be subject to more specific qualifications, preferably with a minimum of investigative or related experience.
  2. Civilian monitors be subject to background checks prior to their engagement.
  3. A pool of qualified potential candidates (including of Indigenous descent) be engaged on a casual contract basis to ensure that qualified civilian monitors are available at short notice.
  4. The civilian monitor reports also be provided to the civilian director, as well as to the minister.
- (Recommendation 67) That civilian monitors be provided contemporaneous access to investigations materials.
- (Alternatively: Recommendation 68) That Manitoba Justice provide the civilian director with the authority to engage a civilian monitor for the purposes of acting as a liaison to the community, particularly for particularly high-profile or sensitive investigations or those involving members of Manitoba’s racialized communities.
- (Recommendation 69) That the Police Services Act (or in IIU-specific legislation as proposed in this Report) be amended to provide that the civilian director may appoint a community liaison or observer to work with the Independent Investigations Unit in the course of an investigation.
- (Recommendation 70) That Manitoba Justice develop the capacity of the office of the Director of Policing to monitor and analyze complaints and conduct-related reports from LERA and IIU, as well as results of standards compliance monitoring inspections to develop a whole-of-system perspective on relevant trends. Furthermore, that the ministry issue an annual report on this matter.

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### **2.2.13. Broken Dreams, Broken Lives: Implementation of the Merlo Davidson Settlement Agreement (RCMP, 2020)<sup>158</sup>**

As part of the settlement of the sexual harassment class action against the RCMP, the Honourable Michel Bastarache, CC, QC, was appointed to assess the individual claims for compensation made by women who had experienced sexual harassment and discrimination based on gender or sexual orientation since 1974 while working for the RCMP. Mr. Bastarache was also asked to

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<sup>158</sup> “Broken Dreams, Broken Lives: The Devastating Effects of Sexual Harassment on Women in the RCMP—Final Report on the Implementation of the Merlo Davidson Settlement Agreement” (“Bastarache Report”). RCMP (November 2020), <https://www.rcmp-grc.gc.ca/en/final-report-implementation-merlo-davidson-settlement-agreement>.

write a report of his observations and recommendations. The conduct that he and his co-assessors confirmed ranged from the use of sexist and homophobic language to refusal to provide backup to female members in dangerous situations to shockingly high numbers of sexual assaults—all of which had profound and long-lasting effects on the claimants.

After he and his co-assessors interviewed 644 women and considered more than 3,000 claims, Mr. Bastarache found that “the RCMP is imbued with a toxic culture that tolerates misogyny and homophobia within its ranks and leadership.”<sup>159</sup> Among the conclusions Mr. Bastarache drew from these interviews were the following:

- The RCMP “is not recruiting the right kind of person to serve in a modern policing organization”;<sup>160</sup> there are problems with low entry requirements, low salary, poor screening of applicants, and high turnover.
- The paramilitary style training given to cadets contributes to the continuation of a toxic culture in the RCMP, and hazing and sexual abuse of female recruits is common.
- The traditional, paramilitary, male-dominated culture of the RCMP, which gave rise to this toxicity, requires a wholesale change of the culture. There are strong reasons to doubt the RCMP has the capacity or will to make these changes.<sup>161</sup>
- The RCMP culture around mental health stigmatizes post-traumatic stress disorder (PTSD) and other mental health issues, punishes members who seek assistance or show “weakness,” fails to respect members’ privacy, and leads members to self-medicate with alcohol—although the Report acknowledged that the force was making changes to its approach to members’ mental health.
- Although the force has made changes to its practices around promotion, more needs to be done to ensure effective leadership at all ranks and to prevent promotions based on the “old boys’ club.”
- Women had brought claims of sexual harassment and discrimination for over 30 years, and there had been at least fifteen reports that had highlighted related issues and made recommendations; however, the implementation of these recommendations was not effective. “The systemic discrimination that prevailed for years has been tolerated.”<sup>162</sup>

Mr. Bastarache noted that in response to some of these reports and reviews, the RCMP created a Gender and Respect Action plan to improve the culture and composition of the RCMP. He noted that in 2014, the RCMP Code of Conduct was amended to state, “Members treat every person with respect and courtesy and do not engage in discrimination or harassment” (s. 2.1).<sup>163</sup>

Mr. Bastarache noted that the 2007 Brown Task Force report on the culture of the RCMP (“Rebuilding the Trust”) had raised the possibility that some or all of the solution to the issues confronting the RCMP “rests in breaking it up.”<sup>164</sup> Mr. Bastarache stated:

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<sup>159</sup> “Broken Dreams, Broken Lives,” p. 45.

<sup>160</sup> “Broken Dreams, Broken Lives,” p. iii.

<sup>161</sup> “Broken Dreams, Broken Lives,” p. 56.

<sup>162</sup> “Broken Dreams, Broken Lives,” p. 36.

<sup>163</sup> “Broken Dreams, Broken Lives,” p. 40.

<sup>164</sup> “Broken Dreams, Broken Lives,” p. 58, quoting “Rebuilding the Trust,” which is summarized at section 2.2.2. above.

Such a fundamental restructuring may be necessary to resolve entrenched issues of misogyny, racism, and homophobia. To do so will require an in-depth review and examination which is clearly beyond my mandate. In my view, however, it is time to discuss the need to make fundamental changes to the RCMP and federal policing. I am of the view that cultural change is highly unlikely to come from within the RCMP. It has had many years and many reports and recommendations and yet the unacceptable behaviour continues to occur. Women who were favourable to a fresh start were of the view that they, as women, would be better accepted.<sup>165</sup>

[...]

The time has come to ask some hard questions about the structure and governance of federal policing in Canada. The past has demonstrated that change cannot come from within the RCMP. There must be a rigorous review of the RCMP followed by changes that will ensure that federal policing is delivered efficiently in a manner compliant with the Charter value of equality and with the Government of Canada's commitment to gender equality, including in the workplace.<sup>166</sup>

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation B1) Perform a careful analysis of what will constitute “merit” in the recruitment of RCMP members, considering the need to remove systemic barriers and to allow for specialized roles and functions.
2. (Recommendation B2) Require a minimum level of two years of post-secondary education or training to apply to the RCMP. The RCMP should study the changes to recruitment recently adopted in the UK, which give options for varying ways to meet this requirement.
3. (Recommendation B3) Encourage applications from diverse groups, including women, LGTQ2S+ people, and racialized communities, and implement programs to assist them in meeting the entry requirements where necessary.
4. (Recommendation B4) Conduct effective and detailed background checks on applicants' views on diversity and women. Eliminate those who are not able to function with women, Indigenous people, racialized minorities, or LGBTQ2S+ persons and are unwilling to accept the principles of equality and equal opportunity for all. Screening must consider all incidents of harassment and domestic violence.
5. (Recommendation C1) The RCMP should appoint an external expert to review the training program at Depot to ensure that it meets the requirements of a modern police force and promotes a positive police training that addresses issues of harassment and discrimination and teaches recruits about the Charter value of equality.
6. (Recommendation C2) During the time required for the external study, the RCMP should establish and enforce a zero-tolerance policy for harassment and discrimination at Depot with meaningful consequences.
7. (Recommendation C3) The RCMP should ensure an effective anti-harassment and discrimination course is taught at Depot that includes role-playing as well as participation by members who have experienced harassing conduct.
8. (Recommendations F1–3) There must be transparency in allocating [training] courses. The RCMP must implement an early and effective career plan for all members that continues

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<sup>165</sup> “Broken Dreams, Broken Lives,” p. 58.

<sup>166</sup> “Broken Dreams, Broken Lives,” p.105.

throughout their career with appropriate accountability for ensuring that the member is effectively supported. This plan should determine the allocation of training and postings. The RCMP should centralize the allocation of training so that the discretion to grant courses no longer rests with a member's direct supervisor.

9. (Recommendations H2–5) The Government must provide sufficient funding to maintain effective human resource levels in all detachments, including when women take maternity leave. The RCMP must ensure that it has a system to ensure that resource levels required for operational duties are always maintained—on an organization-wide basis, not on a division-by-division basis—over the next 2–3 years. Positions should be backfilled so that women are not resented for having children. The idea of floaters—members that can be deployed where necessary to ensure appropriate coverage—should be endorsed.
10. (Recommendations M1–2) Leadership training should begin at Depot and be continually emphasized throughout a member's career. Members should be required to recommit to upholding the Code of Conduct every time they are promoted.
11. (Recommendations M4) Ensure that all leadership training is done in-person and involves role-playing exercises, which are key adult learning programmes. Online courses or non-participatory classes are insufficient.
12. (Recommendations M5) Require a complete evaluation of commissioned officers every 3–5 years and in any event before they are promoted again.

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#### **2.2.14. Chairperson-Initiated Complaint and Public Interest Investigation into the RCMP Investigation of the Death of Colten Boushie (Civilian Review and Complaints Commission for the RCMP, 2021)<sup>167</sup>**

This review investigated the RCMP's work in the death of Colten Boushie, a young Indigenous man who was shot and killed by Gerald Stanley in Saskatchewan in 2016. Mr. Stanley was acquitted of second-degree murder and manslaughter in 2018.

The Ford Escape in which Mr. Boushie and four friends were driving home had a flat tire. They turned into Mr. Stanley's driveway and stopped in Mr. Stanley's yard. Two of Mr. Boushie's friends got out of the car and interacted with a truck on the property. Mr. Stanley and his adult son yelled at Mr. Boushie's friends, and they got back in the car and tried to drive away. Mr. Stanley's son chased them and hit their windshield with a hammer. They collided with another vehicle and got stuck. Two of the friends fled on foot. Mr. Stanley approached the driver's side door with a gun in hand. The gun discharged, shooting Mr. Boushie in the head. (Mr. Stanley claimed at trial that the gun discharged in a "hang-fire" incident.)

Mr. Stanley's son called 911 at 5:27 PM. RCMP members arrived between 6:10 and 6:35 PM. They arrested Mr. Stanley, his wife, and his son. They cleared the residence and outbuildings by 6:52 PM. Emergency medical services personnel examined Mr. Boushie and declared him deceased.

The RCMP did not obtain a search warrant for the Stanley property until the evening after the shooting, and the search started the morning after the search warrant was obtained. The RCMP

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<sup>167</sup> "Final Report: Chairperson-Initiated Complaint and Public Interest Investigation into the RCMP's Investigation of the Death of Colten Boushie and the Events that Followed." Civilian Review and Complaints Commission for the Royal Canadian Mounted Police (January 2021), <https://www.crc-cetp.gc.ca/en/commissions-final-report-cic-pii-ColtenBoushie-Events>.

did not appear to consider numerous options available to them to obtain the warrant sooner. They also chose not to start the search immediately after obtaining the warrant. They took no steps to cover the Ford Escape, despite the delay in obtaining the warrant and a forecast of rain. The rain destroyed the bloodstain patterns in the car and altered evidence. The CRCC Report noted that it will never be known what difference the loss of this evidence may have had on the outcome of the case. The CRCC found that this was a significant error in the investigation into Mr. Boushie's death, which showed a lack of appreciation or concern for the integrity of the evidence. The Commission attributed this error in part to a lack of communication between the various officers and units involved in the investigation. The Report also noted that two of the officers failed to adequately document their handling of physical evidence in their notes.

No member of the Major Crimes Unit attended the crime scene in the initial days after the shooting, despite having opportunity to do so. The CRCC noted that if they had attended the scene, they could have significantly improved the investigation. For example, their input at the scene might have led the officers to obtain the search warrant earlier and to protect the Ford Escape from rain. A Forensic Investigation Service technician who had no training as a Forensic Investigation Specialist was left on scene to process the crime scene on his own for three hours. This was unreasonable and contrary to RCMP policy.<sup>168</sup>

The CRCC found there was an issue with staffing at the detachment. It also found that a mobile command centre could have improved crime scene management and communications. It otherwise found that the RCMP investigation of Mr. Boushie's death was generally professional and reasonable. The initial response was timely, the interview with Mr. Stanley was reasonably conducted, and the investigative team was adequately staffed.

While on their way to Mr. Stanley's farm, RCMP officers had encountered three of Mr. Boushie's friends. They were arrested for mischief and lodged in cells overnight. The CRCC found that the arrests of Mr. Boushie's friends were unreasonably conducted. Their continued detention after they gave their statements was also unreasonable and not legally justified.

By contrast, Mr. Stanley's wife and son were released from custody following their arrest and permitted to take a vehicle from the crime scene and travel together on their own to a detachment to provide voluntary witness statements. They were not asked not to speak with each other. The CRCC found that it was unreasonable for the RCMP to allow Mr. Stanley's wife and son to remove their vehicle from the crime scene. The RCMP also should have separated them before they provided their statements.

A significant issue addressed by the CRCC was the RCMP's communication with the family of the deceased. The CRCC said, "The importance of effective communication with families in the context of major case investigations cannot be overstated."<sup>169</sup> RCMP members who notified Ms. Baptiste of her son's death treated her with profound insensitivity. Immediately after they told her that Mr. Boushie was deceased, one member asked her if she had been drinking; when she showed distress, a member told her to "get it together." One or more of them smelled her breath. When Ms. Baptiste said she had put Mr. Boushie's dinner in the microwave when he didn't come home for dinner, a member checked the truth of that statement by looking inside the microwave.

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<sup>168</sup> The CRCC Report noted that in its response to the CRCC preliminary report, the RCMP Commissioner disagreed with this finding based on a differing interpretation of its policy. The CRCC concluded that this was not sufficient ground for rejecting a CRCC finding.

<sup>169</sup> "Final Report into the Death of Colten Boushie," p. 19.

The CRCC noted the impact of colonialism and its collective traumas and noted that this history affected the current relationship between Indigenous peoples and the RCMP. It concluded that the RCMP's conduct toward Ms. Baptiste with respect to her sobriety and credibility was discriminatory on the basis of her race, national or ethnic origin. Although other aspects of the RCMP's conduct could be indications of discrimination, the CRCC concluded that there were other plausible explanations for the conduct.

RCMP members also attended the funeral hall where Mr. Boushie's wake was being held; they said they did so in order to provide an update about the investigation. The CRCC found that this was unreasonable and further harmed the relationship between the family and the RCMP. It noted that the criminal investigation had already prevented the family from having access to Mr. Boushie's body, impeding their ability to follow their cultural practices. The arrival of the RCMP members at the funeral hall intruded on their grief and upset Mr. Boushie's mother at a moment of "acute emotional vulnerability."<sup>170</sup>

The CRCC noted that Indigenous-related training is not mandatory for RCMP members, despite the RCMP being responsible for policing 40% of the Indigenous population in Canada. The CRCC noted that its recommendation of cultural awareness training for all employees "is not a new recommendation in the context of policing"<sup>171</sup> and emphasized that such training should be done in accordance with recommendations made in other inquiries over the past 30 years, including that it be ongoing through an officer's career, trauma-informed, experiential, with Indigenous, Inuit, and Metis police officers as course leaders, and knowledgeable about traditional restorative justice principles.

The RCMP Commissioner accepted all of these findings, including the discriminatory treatment of Ms. Baptiste, and accepted all the recommendations. However, the CRCC expressed concern that the RCMP response focused on minor and technical points rather than the issues at the heart of the case and was therefore a "missed opportunity for the RCMP to take responsibility for the manner in which Mr. Boushie's family and friends were treated." It recognized that the RCMP expressed a clear commitment to provide enhanced cultural awareness and Indigenous-related training and had referred to numerous training programs and resources being put in place to address this issue. The CRCC stated:

Achieving the deeper change to the RCMP's organizational culture that will prevent the type of discrimination found in this case from reoccurring will require more than cultural awareness training. However, the CRCC notes the positive steps the RCMP is taking and hopes that this case and the present report can be part of the catalyst for the RCMP to further engage in a necessary process of change.<sup>172</sup>

In addition to its findings regarding the RCMP's investigation into Mr. Boushie's death, the CRCC raised serious concerns with the RCMP's approach to the CRCC investigation. First, the RCMP was slow to provide requested material to the CRCC, and the CRCC was required to make several requests for relevant material.

Second and more significantly, the RCMP had destroyed recordings and transcripts of telephone calls and radio communications two years after their creation, after deciding they had no evidentiary value to the criminal investigation. This was done pursuant to the RCMP's

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<sup>170</sup> "Final Report into the Death of Colten Boushie," p. 81.

<sup>171</sup> "Final Report into the Death of Colten Boushie," p. 23.

<sup>172</sup> "Final Report into the Death of Colten Boushie," p. 2.

documentary retention policy, which allows for the destruction of certain investigative records after two years. The CRCC noted that in addition to the public interest investigation, the family had made a separate complaint; the destroyed material was relevant to both these investigations, which had each started prior to the close of the two-year window.

Third, the RCMP conducted an Independent Administrative Review Report (IAR) into its investigation of Mr. Boushie's death.<sup>173</sup> The RCMP did not disclose the existence of the IAR or relevant materials it obtained during its investigation, including witness interviews, to the CRCC until after the CRCC issued its interim reports on the matter. The CRCC stated that these materials were "undoubtedly relevant" to the CRCC investigation and were clearly covered by the CRCC's ongoing request for relevant materials. The CRCC was especially concerned about the RCMP decision to have the IAR interview witnesses, many of whom were also interviewed by the CRCC, without disclosing its plans to the CRCC in order to ensure there was no interference with the CRCC investigation. The CRCC also noted that although the IAR was described as "independent," it was led by RCMP members, and only RCMP members were consulted as experts. The IAR did not interview members of the Boushie family. The CRCC stated that it expects the RCMP to inform the CRCC in future cases when it conducts internal reviews into matters being investigated by the CRCC.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. That Corporal Fee and Constable Teniuk be provided with operational guidance with respect to RCMP policy regarding the interviewing of witnesses.
2. That Corporal Fee and Constables Wright and Teniuk be directed to review the RCMP national policy OM 24.1. ("Interviews/Statements: Suspect/Accused/Witness").
3. That the RCMP ensure that adequate resources are available in a timely manner for the investigation of major crimes.
4. That RCMP senior management in "F" Division consider acquiring a Mobile Command Centre.
5. That in future cases, the Major Crime Unit Commander ensure that a member of the Unit attend the crime scene in a timely fashion.
6. That Constables Doucette and Park be directed to review the policy OM 25.2. ("Investigator's Notes").
7. That cultural awareness training be provided for all RCMP employees bearing in mind the factors identified in recent inquiries.

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### **2.2.15. Systemic Racism in Policing in Canada (Standing Committee on Public Safety and National Security, 2021)<sup>174</sup>**

The House of Commons Standing Committee on Public Safety and National Security (SECU) issued this report in June 2021. Its mandate was to study systemic racism in policing services in

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<sup>173</sup> Inspector Daniel Almas, Superintendent Darcy Fleury, "Independent Administrative Review of the 'F' Division RCMP Investigation Relating to the Homicide of Mr. Coulton Boushie," January 13, 2020 COMM0063045 exhibited within the Mass Casualty Commission's proceedings at P-004214.

<sup>174</sup> "Systemic Racism in Policing in Canada: Report of the Standing Committee on Public Safety and National Security." House of Commons (June 2021), <https://www.ourcommons.ca/Content/Committee/432/SECU/Reports/RP11434998/securp06/securp06-e.pdf>.

Canada, particularly within the RCMP. It was also required to consider relevant sections of the Final Report on the implementation of the Merlo Davidson Settlement Agreement (the “Bastarache Report,” summarized above in section 2.2.7.). The Standing Committee heard from 53 witnesses, including community organizations, advocates, academics, and police representatives.

The Committee noted that “systemic racism is both a social and legal concept connoting a particular type of racism which occurs within social systems and is reproduced by them.”<sup>175</sup> It quoted Senator Murray Sinclair’s explanation of how systemic racism works:

Systemic racism is when the system itself is based upon and founded up on racist beliefs and philosophies and thinking and has put in place policies and practices that literally force even the non-racists to act in a racist way.<sup>176</sup>

Systemic racism includes structural racism, whereby policies, practices, and norms perpetuate racial inequality, and institutional racism, whereby policies and practices produce outcomes that work in favour of some groups to the disadvantage of others. Systemic racism is premised on white supremacy, which rewards privileges to white people and denies those privileges to Black, Indigenous, and other people of colour. Systemic racism is deeply embedded in Canada’s colonial history.

The Committee noted the role of accountability, oversight, and transparency in addressing systemic racism in policing. Witnesses had identified a lack of accountability within the RCMP for systemic racism and discriminatory misconduct by its members toward the public and between members. They also raised concerns about the resources, powers, and structure of the Civilian Review and Complaints Commission for the RCMP (CRCC).<sup>177</sup>

The RCMP is required to respond to CRCC findings and recommendations, explaining what actions it is taking or will take or, if it decides not to act on any of the findings, its reason for making that decision. However, the RCMP is not required to provide this response within any particular timeline. The average response time is seventeen months, and in one case had extended to two years. The RCMP and CRCC have entered into a memorandum of understanding regarding timelines<sup>178</sup>, but it is not legally enforceable.

Moreover, there is no mechanism to ensure that the RCMP implements CCRC recommendations. The CCRC cannot sanction the RCMP or order it to implement any of its recommendations, and the RCMP is not required to report on the status of implementation of recommendations it undertakes to implement.

The CRCC also lacks sufficient funding and resources to fulfill its mandate, including public interest investigations and reports on systemic issues. Its process is also overly complex, making it inaccessible for many who might file complaints. The CRCC chairperson, Michelaine Lahaie,

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<sup>175</sup> “Systemic Racism in Policing,” p. 17.

<sup>176</sup> “Systemic Racism in Policing,” p. 17, quoting Senator Murray Sinclair in S. Bein, “Morning Update: RCMP Commissioner ‘Struggles’ with Definition of Systemic Racism, but Denies It Exists on Force” *Globe & Mail*, 11 June 2020, <https://www.theglobeandmail.com/canada/article-morning-update-rcmp-commissioner-struggles-with-definition-of/>.

<sup>177</sup> Many of these concerns were noted by the CRCC Chairperson, Michelaine Lahaie, in her testimony before the Committee. See Evidence, SECU (43-1) - No. 10 (24 July 2020) House of Commons, <https://www.ourcommons.ca/DocumentViewer/en/43-1/SECU/meeting-10/evidence>

<sup>178</sup> This Memorandum of Understanding is available here: <https://www.crcc-ccetp.gc.ca/en/mou-crcc-and-rcmp>

told the Committee that the process can be bureaucratic and difficult to navigate. Indigenous community members often reported not being aware of the CRCC or a lack of trust in it. Although the CRCC has taken some steps to improve accessibility, such as translating its complaint forms into additional languages, including Inuktitut, and making staff available to help complainants, it needs to do more. Although its staff was found to be fairly diverse, it does not have adequate Indigenous representation.

Some witnesses also suggested improvements to internal RCMP management, including making all disciplinary decisions public and more accountability for middle managers who do not take appropriate steps in response to claims of harassment and discrimination. The RCMP Commissioner has the option but is not required to seek the advice of the RCMP civilian Management Advisory Board and is not required to follow that advice when they do seek it. That process is not transparent. The Committee also noted that witnesses, including the Honourable Michel Bastarache, testified that the RCMP “does not appear to be capable of addressing systemic discrimination within the organization itself, suggesting change must be imposed and overseen externally.”<sup>179</sup>

Although a number of police leaders told the Committee that they were committed to implementing structural reform to address systemic racism, others were of the view that because of the paramilitary structure of some forces, including the RCMP, they would require civilian oversight to ensure they engaged in the necessary reforms. The RCMP senior management structure has not changed for decades. Some witnesses suggested that the leadership be replaced with civilians rather than uniformed members, which would improve its diversity and provide expertise in policy, communications, human resources, and finance. Witnesses suggested that the RCMP requires a professional rather than paramilitary model.

Witnesses also expressed concerns about the mandatory training of all RCMP recruits at Depot Division in Regina. This training makes RCMP members less flexible and adaptable to the diverse communities that the RCMP serves and instills a “command and control” mindset. The Hon. Michel Bastarache said that claimants in the Merlo Davidson class action experienced sexual abuse, harassment, and discrimination during Depot training, and they considered it worse than other police training because it was designed to break the cadets down and rebuild them. Alternatives to this training suggested during the Committee’s hearings included community-based training to ensure RCMP members understand the needs of the communities they serve; or a national policing college that delivers professional, evidence-based training and could set policing standards, similar to the College of Policing model in the United Kingdom.

Witnesses also expressed concern about whether the RCMP contract policing arrangements, which involve a top-down governance model rather than local governance, could provide policing services that are responsive to each community’s unique issues and needs.

The Committee also heard evidence about Indigenous policing services. The First Nations Policing Program, through which First Nations and Inuit communities can manage their own police services, lacks stable funding and is chronically underfunded compared to other police services. Indigenous police services have been declining rather than growing, possibly due to the lack of funding. The Committee noted some innovative Indigenous policing structures designed to provide service that is more responsive to community needs, such as Community Safety Officers (CSOs) in the Kwanlin Dun First Nation. These officers are trained in conflict resolution and work

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<sup>179</sup> “Systemic Racism in Policing,” p. 25.

alongside police officers to de-escalate situations and provide culturally responsive services. Community members can call these CSOs rather than involve the RCMP, which has reduced calls for service to the police and allows the community to resolve issues on their own. However, the CSO program faces funding challenges.

Witnesses explained the lack of trust in the police felt by First Nations, Métis, and Inuit communities, referring to police participation in enforcing the residential schools program and child apprehensions during the Sixties Scoop, forcibly relocating families and communities, slaughtering Inuit sled dogs, and failing to prevent and properly investigate the disappearances and murders of Indigenous women and girls. Witnesses also spoke to the current evidence of systemic racism against Indigenous people in the justice system, noting that First Nations people are more likely to be detained, are detained longer, are sentenced to longer prison terms, are more likely to be imprisoned for nonpayment of fines, and more likely to be killed during police actions than are other Canadians. Inuit witnesses explained that Inuit Nunangat, the homeland of Inuit people,<sup>180</sup> is almost entirely policed by the RCMP. They described the RCMP as lacking any significant connection to the communities they serve and failing to understand their culture or language. They also identified a lack of services to assist victims of gender-based violence in Inuit communities, such as shelters. The Committee noted the existence of several previous reports dealing with policing in Indigenous communities: “Witnesses expressed dismay that many of the recommendations contained in previous reports have not yet been actioned and demanded these recommendations be acted upon.”<sup>181</sup> Witnesses also noted that Indigenous communities had a long history of justice and public safety prior to colonization and must be provided with jurisdiction over policing in their own communities, with an emphasis on self-determination. In urban communities, police need more education about the lived experience of colonization, mental health, and addiction. Urban police services also need more Indigenous staff, including Elders.

The Report addressed the impact of racism in policing on Indigenous women and girls in particular, in the form of excessive use of force, unwarranted strip searches, harassment and sexual assault by police, racial profiling, failure to assist victims of sexual violence, and failure to protect them from gender-based violence and homicide. The failure to properly respond to the disappearance and murder of Indigenous women and girls, highlighted in the report of the National Inquiry into Missing and Murdered Indigenous Girls and Women (summarized in section 6.2.7. below), was also considered by the Committee. The Report noted the evidence of government and RCMP witnesses as to steps they were taking in light of that report, such as reviews of policing practices and a national RCMP office of investigative standards and practices.

The Committee considered the role of systemic racism in police responses to people experiencing mental health crises. Racialized people may lack access to services, leaving the police as their only source of assistance; the trauma of racism experienced by Indigenous and other racialized people can also cause or exacerbate mental health problems. Police witnesses, including RCMP Commissioner Brenda Lucki, said that calls to police resulting from mental health crises are growing exponentially and make up a significant proportion of all calls to police. However, police are not trained to properly address mental health issues, and research has shown that traditional police responses are ineffective. A number of witnesses called for a shift in funding to support community organizations to provide services for Indigenous and other racialized people, including mental health responses. Programs such as the Community Safety Officer program in Kwanlin Dun First Nation, which allows specially trained Indigenous people to respond to and de-escalate

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<sup>180</sup> Inuit Nunangat includes parts of the Northwest Territories, Nunavut, Quebec, and Newfoundland and Labrador.

<sup>181</sup> “Systemic Racism in Policing,” p. 37.

crises instead of police, can reduce police-involved deaths and the use of police force against racialized people during responses to mental health calls.

Police street checks, carding,<sup>182</sup> and over-policing (heightened police presence in racialized and Indigenous communities) were identified as mechanisms by which the discretionary powers of police can be exercised in discriminatory ways, leading to the over-representation of Indigenous and racialized people in the justice system. The Report identified police checks and carding as forms of racial profiling, the conscious or unconscious application of stereotypes about racial groups when police stop, arrest, or charge people, and noted statistics regarding the gross overrepresentation of Black men among the people subjected to these practices.

The Committee considered options for reducing the over-representation of Indigenous and other racialized people, including restorative justice programs, diversion, anti-discriminatory, and culturally specific services for African Canadian offenders, and decriminalization of drug possession.

Indigenous and other racialized people are over-represented among victims of police use of force and police-involved deaths. Some witnesses suggested that laws on self-defence and police use of force should be reformed. The current Criminal Code provisions on self-defence do not concretely define the “reasonable use of force,” leading to the creation of different police policies on the use of force across the country. Witnesses suggested the creation of a clear federal standard for the use of force, with input from civilians, women, Indigenous, and other racialized groups. They also suggested that more emphasis should be placed on developing police skills on de-escalation and interacting with the public.

Training was a frequent topic during the Committee’s study. One witness suggested, “A complete re-education of the entire police system is required. This training must go beyond a tick box of cross-cultural training [and] must cause the system and participants to fully examine their biases, both overt and unconscious.”<sup>183</sup> RCMP Commissioner Brenda Lucki testified that cadets engage in the “blanket exercise” to learn about the history of Indigenous cultures, as well as a mandatory online cultural awareness course and trauma-informed approaches to dealing with victims of crime. She also said that RCMP members complete a one-week course on “Indigenous perspectives,” specific to the province in which they have been assigned. The Committee noted examples of suggestions witnesses had made for improvements to existing training but also noted that some witnesses were skeptical about the extent to which training can address systemic racism.

RCMP Commissioner Lucki testified that the RCMP is working to remove barriers to diversity in recruitment. Currently its officers are 78% male, 21% female; 11.5% visible minority; 7.5% Indigenous; and 1.6% are people with disabilities. Witnesses identified serious problems with the representation of Inuit communities among the RCMP and noted that the itinerant nature of RCMP service, whereby members are not allowed to remain in their home communities, contributes to this problem. The internal identity struggle required by Indigenous people to join a force that has historically harmed their communities was also identified as a barrier to increased Indigenous

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<sup>182</sup> A police street check occurs when an officer obtains information about a person outside a police station, unconnected with an investigation. Carding occurs when an officer asks a person to provide identifying information when there is no reason to believe the person is involved in a crime or has information about a crime. The terms are often used interchangeably.

<sup>183</sup> “Systemic Racism in Policing,” p. 64, quoting Melanie Omeniho.

membership in the RCMP. Racialized members of police services also report experiencing rejection by the police subculture and being passed over for assignments and promotion.

The Committee heard evidence about the importance of promoting the comprehensive collection of disaggregated race-based data to identifying problems with the practices or policies of police agencies and to evaluate the success of reforms. Witnesses did, however, express concern about the potential for misuse of this data to reinforce racist stereotypes.

### **The Bastarache Report**

As noted, the Committee was required to consider “Broken Dreams, Broken Lives,” also known as the “Bastarache Report,” and heard evidence from Mr. Bastarache. Mr. Bastarache testified that many of the complainants told him that the harassment and abuse detailed in his report was still ongoing. He described the internal culture of the RCMP as toxic and how even the “good” members of the RCMP feel no choice but to stay silent rather than speak up against that culture. The Committee noted the disturbing findings set out in the Bastarache Report, in particular its skepticism that internal change is possible at the RCMP. It also referred to the Report’s recommendation for the establishment of a commission of inquiry to examine options for the future of the RCMP, including its replacement by a new federal police agency.

The Committee concluded its study by stating that “systemic racism in policing in Canada is a real and pressing problem to be urgently addressed”<sup>184</sup> but acknowledged that although many previous studies on the issue had made findings and recommendations, the resulting changes had failed to remedy the harms felt by Indigenous and other racialized people in Canada.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 1) That the Government of Canada clarify and strengthen the mandate, independence and efficacy of the Civilian Review and Complaints Commission for the Royal Canadian Mounted Police (CRCC) by:
  - a. substantially increasing its annual funding to ensure sufficient resources for both complaint reviews and systemic reviews;
  - b. amending the Royal Canadian Mounted Police Act to:
    - empower the CRCC to, when conducting investigations of the Royal Canadian Mounted Police (RCMP) that raise a reasonable belief that the matter involves criminal conduct, refer cases to the appropriate body responsible for criminal investigations of police conduct or recommend to the relevant authorities that criminal charges be laid;
    - create statutory timelines for responses by the RCMP Commissioner to CRCC reports, codifying the schedule established in Appendix A of the Memorandum of Understanding between the CRCC and the RCMP;
    - require the Commissioner of the RCMP to report annually to the Minister of Public Safety and Emergency Preparedness, describing steps taken to implement CRCC recommendations and require this report to be tabled in Parliament; and
    - require the CRCC to publish its findings and recommendations or a summary thereof in respect of all complaints in a manner that protects the identity of the complainant.

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<sup>184</sup> “Systemic Racism in Policing,” p. 75.

2. (Recommendation 2) That the Government of Canada increase the accessibility and transparency of the Civilian Review and Complaints Commission for the Royal Canadian Mounted Police review process by:
  - c. reforming the process for initiating a complaint with the CRCC to make it easier to navigate;
  - d. ensuring the independent review process is explained in a detailed and accessible format, including information about when the CRCC has completed its interim report and when the RCMP's review of the report began and was completed;
  - e. making sure the progression of a review and the reports involved in it are transparent and publicly available with few exceptions; and
  - f. publicly specifying the conditions for all exceptions to public accessibility and transparency.
3. (Recommendation 3) That the Government of Canada ensure the Civilian Review and Complaints Commission for the Royal Canadian Mounted Police review process allows for meaningful and engaged Indigenous participation and holds the RCMP accountable for wrongful, negligent, reckless, or discriminatory behaviour towards Indigenous people by requiring the CRCC to:
  - g. consult with local Indigenous groups where complaints or systemic reviews involve Indigenous complainants;
  - h. include Indigenous investigators and decision-makers in the CRCC; and
  - i. ensure Indigenous investigators are involved where the complaint involves Indigenous people.
4. (Recommendation 4) That the Government of Canada appoint Indigenous, Black and other racialized people, and residents of Northern communities to the Civilian Review and Complaints Commission for the Royal Canadian Mounted Police, and to investigations and leadership positions within that organization.
5. (Recommendation 5) That the Government of Canada mandate that the Royal Canadian Mounted Police implement effective ongoing training and disciplinary policies for RCMP officers in order to prevent excess use of force, systemic racism and racial profiling, and require the RCMP to publish and publicly disclose all disciplinary decisions.
6. (Recommendation 6) That the Government of Canada in collaboration with the Royal Canadian Mounted Police introduce requirements for management at all levels to report and act on internal harassment complaints, with clear and appropriate consequences for failing to do so, and to provide appropriate supports, including mental health supports, for officers who come forward with a complaint.
7. (Recommendation 7) That the Royal Canadian Mounted Police provide to Parliament, annually for three years, a report on the progress of the implementation of the recommendations in this report.
8. (Recommendation 8) That the Royal Canadian Mounted Police be transitioned away from a paramilitary force into a police service model with civilian oversight through a new national oversight board with a legislated mandate to make this transition and the changes required to ensure that policies, practices, procedures, and operations are free from systemic bias and discrimination and that individual acts of discrimination and racism are not tolerated.
9. (Recommendation 9) That the Government of Canada, in consultation with Indigenous, Black, and other racialized people, create a National Police College to provide preparation,

training and education necessary for modern, professional and bias-free policing, including:

- j. course offerings for continuing education, professionalization and specialization;
  - k. the provision of high-quality cultural diversity training for Royal Canadian Mounted Police recruits and other interested police services members; and
  - l. mandatory crisis resolution and psychology courses.
10. (Recommendation 10) That the Government of Canada explore the possibility of ending contract policing within the Royal Canadian Mounted Police and that the Government work with the provinces, territories and municipalities to help those interested establish their own provincial and territorial police services.
11. (Recommendation 11) That the Government of Canada provide funding to all Indigenous communities who are interested in Community Safety Officer programs based upon the Kwanlin Dün First Nation model.
12. (Recommendation 12) That the Government of Canada work with Indigenous peoples to prioritize action on all recommendations by commissions and inquiries regarding systemic racism against Indigenous peoples in policing and the justice system with the aim of implementing the unfulfilled recommendations, with attention to the recommendations from the Truth and Reconciliation Commission: Calls to Action and Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls that relate to policing.
13. (Recommendation 13) That the Government of Canada, through consultation and partnership with First Nations, Inuit and Métis communities, and recognizing that decisions surrounding policing must be community driven, develop an Indigenous Police Services Framework designed to promote self-determination and self-governance over policing to Indigenous communities; this framework should include:
- m. the designation of Indigenous police services as essential services and a requirement that they are adequately resourced;
  - n. provision for the co-development, in consultation and cooperation with Indigenous peoples, of a model of civilian oversight for Indigenous police services, with the authority to audit such services and investigate claims of police misconduct; and
  - o. a commitment for the provision of sufficient funding and support to enable all interested Indigenous communities to develop Indigenous police services.
14. (Recommendation 14) That the Government of Canada in collaboration with First Nations, Métis and Inuit communities and through negotiation, and in consultation with Indigenous leaders and organizations, offer to create specialized training rooted in Indigenous cultural knowledge and history.
15. (Recommendation 15) That with the financial support of the Government of Canada, Indigenous policing models be developed in urban communities with significant Indigenous populations, in consultation and cooperation with local Indigenous people and local police authorities, to cooperate in policing, with:
- p. advisory bodies resourced and financed appropriately;
  - q. Indigenous policing units within the urban police services;
  - r. special patrols with Indigenous officers or community support;
  - s. or such other models or arrangements that are appropriate to the local circumstances as may be agreed upon.

16. (Recommendation 16) That the Government of Canada provide necessary resources and work with Inuit stakeholders on an Inuit-led consultation within Inuit communities on the most appropriate and effective model of policing of Inuit communities, should they desire to undertake such consultations.
17. (Recommendation 17) That the Royal Canadian Mounted Police ensure that in all jurisdictions where they are the police service responsible for First Nations, Métis and Inuit communities, that a family liaison officer, and wherever reasonably possible, one female officer is available to address gender-based violence.
18. (Recommendation 18) That the Government of Canada encourage the Royal Canadian Mounted Police to develop an action plan with concrete measures to address systemic racism and violence against Indigenous women using an intersectional approach, taking into account the different types of discrimination Indigenous women face and how these types of discrimination intersect.
19. (Recommendation 19) That the Royal Canadian Mounted Police establish programs and review and revise policies to encourage officers who are stationed in First Nations, Métis, Inuit and Northern communities to accept longer postings in order to better establish ties with the communities they are serving.
20. (Recommendation 20) That the Government of Canada work with the provinces and territories, municipalities and Indigenous communities to ensure adequate funding and service responsibilities related to mental health response and victim services.
21. (Recommendation 21) That the Government of Canada work with the Royal Canadian Mounted Police, and provincial and municipal police services to encourage the use of persons specialized in victim services and mental health who would be available with first responders in situations requiring de-escalation.
22. (Recommendation 22) That the Government of Canada properly resource the Civilian Review and Complaints Commission for the Royal Canadian Mounted Police to conduct an independent review of RCMP operational policies and practices such as “wellness checks” and develop a timeline for corrective action to end police violence and ensure the safety and security of those in need of mental health support.
23. (Recommendation 23) That the Government of Canada work with the provinces and territories to create an Indigenous-led working group to better examine the service needs related to mental health and victim services of the rapidly growing urban Indigenous population and ensure that mental health responses, victim services and community safety and policing programs serving Indigenous people living in urban areas are adequately resourced.
24. (Recommendation 26) That the Government of Canada adopt a national policy that prohibits racial profiling and other forms of selective identification and recording of the presence of members of the public other than for investigative purposes and denounces such practices as discriminatory and contrary to the Canadian Charter of Rights and Freedoms.
25. (Recommendation 29) That the Government of Canada develop a national strategy to address and correct the disproportionately high rates of Indigenous and Black people in the criminal justice system and ensure anti-discriminatory and culturally specific services for Indigenous and Black people.

26. (Recommendation 30) That the Government of Canada work in consultation with civilians, Indigenous peoples, and Black and other racialized Canadians, to review the federal use of force framework to ensure that it:
  - t. defines permissible use of force in greater detail;
  - u. provides requirements for the operational use of de-escalation tactics;
  - v. prioritizes de-escalation in use of force philosophy, tactics and training;
  - w. respects as a guiding principle that officers use the least force necessary in the circumstances; and
  - x. requires adequate ongoing training of officers.
27. (Recommendation 31) That the Government of Canada request that the Royal Canadian Mounted Police create a nationwide database of police use of force incident data disaggregated by race, colour, ethnic background, national origin, gender and other identities; regularly collect this data by implementing a mandatory reporting policy, and regularly publicize the data collected.
28. (Recommendation 32) That the Government of Canada work with provinces, territories, police services and chiefs of police across the country to develop a similar national database including all Canadian police services.
29. (Recommendation 33) That the Royal Canadian Mounted Police enforce its zero-tolerance policy for excessive use of force and that there be serious consequences for excessive use of force regardless of whether the threshold is met to lay criminal charges against the officer involved.
30. (Recommendation 34) That the Government of Canada ensure that the Royal Canadian Mounted Police work in collaboration with First Nations, Métis and Inuit communities to establish advisory committees composed of elders, community leaders and cultural facilitators to ensure police practises and procedures address community needs.
31. (Recommendation 35) That the Royal Canadian Mounted Police improve training to ensure that it includes enhanced de-escalation, implicit bias, gender-based violence, cultural awareness, and the history of colonialism and slavery in Canada.
32. (Recommendation 36) That the Royal Canadian Mounted Police mandate that officers receive specific cultural competency training developed in collaboration with the racialized, First Nations, Inuit, and Métis communities they intend to serve.
33. (Recommendation 37) That the Government of Canada in collaboration with First Nations, Métis and Inuit communities prioritize the recruitment of Indigenous people and women into Indigenous police services.
34. (Recommendation 38) That the Government of Canada encourage the Royal Canadian Mounted Police to ensure diversity in hiring for all levels within the police service so that it better reflects the communities that it serves, specifically with a goal of hiring more Indigenous and racialized people, and women.
35. (Recommendation 39) That the Royal Canadian Mounted Police be encouraged to review their screening process for new recruits to ensure that those with biases against Indigenous and racialized people and women be rejected.
36. (Recommendation 40) That the Royal Canadian Mounted Police be encouraged to take into consideration Inuit language skills and community knowledge when evaluating candidates and making decisions surrounding deployment of officers.

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### 2.2.16. Missing and Missed: Independent Civilian Review into Missing Person Investigations in Ontario (Toronto Police Services Board, 2021)<sup>185</sup>

Between 2010 and 2017, serial killer Bruce McArthur murdered eight men with ties to Toronto's Gay Village. All of the victims were gay or bisexual, and six of the eight were men of colour. Six of the eight victims were reported missing and their disappearance investigated by the Toronto Police Service (TPS), but the perpetrator was not identified until his last victim, a white man, disappeared. In early 2018, the TPS arrested Mr. McArthur. Several other people from vulnerable communities, not linked to Mr. McArthur, went missing during this period.

The Toronto Police Services Board appointed retired Ontario Court of Appeal justice Gloria Epstein to review the TPS investigations of missing persons. Ms. Epstein's terms of reference required her to examine the cases of Mr. McArthur's victims, as well as two women, one of whom was trans, who also disappeared during the same period.

Ms. Epstein's review found significant errors in the investigations of these missing persons, including:

1. The September 2010 disappearance of Mr. McArthur's first victim, Skandaraj Navaratnam, was not investigated as it should have been, given the obviously suspicious nature of his disappearance. For example, investigators failed to analyze his computer for years, which would have revealed messages from Mr. McArthur.
2. Toronto police took no steps to inform other regional forces of Mr. Navaratnam's disappearance. Ms. Epstein referred to the conclusion of Justice Archie Campbell in his report on the Paul Bernardo investigation (summarized below in section 3.3.) that "the siloing of information between police services prevents the identification of a serial predator."<sup>186</sup>
3. No serious assessment of the disappearances of two other victims, Abdulbasir Faizi in December 2010 and Majeed Kayhan in October 2012, was conducted, despite obvious red flags that the disappearances involved foul play, nor did investigators draw connections between these disappearances for several years.
1. Mr. McArthur had been convicted in 2001 of attacking a member of the LGBTQ2S+ communities with a lead pipe for no apparent reason. He pleaded guilty to two offences and was banned from the Village for three years.<sup>187</sup> In 2013, Mr. McArthur was interviewed during the investigation of three of the missing men, but the officer interviewing him did not review Mr. McArthur's history and was unaware of these convictions.
2. During the 2013 interview, Mr. McArthur disclosed significant connections to the three men whose disappearances were being investigated, but this did not raise flags with the investigators. Those connections were not entered into any of the police databases, nor was the fact of the interview itself. That failure strongly contributed to the fact that Mr. McArthur was not identified as a potential suspect in any of the disappearances until September 2017.
3. In 2016, Mr. McArthur was arrested for choking a gay man following a sexual encounter. The victim called 911 immediately following the assault. The investigator, Sergeant Paul Gauthier,

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<sup>185</sup> "Missing and Missed: Report of the Independent Civilian Review into Missing Person Investigations." Toronto Police Services Board (April 2021), <http://torontopolice.on.ca/missing-and-missed-implementation/the-report.php>.

<sup>186</sup> "Missing and Missed," volume I, p. 17.

<sup>187</sup> The Report noted that Mr. McArthur was not recognized as a predator, despite evidence to the contrary, and was determined to be of low risk of reoffending, despite there being no explanation for his attack.

accepted that the victim had not consented to being choked. However, Mr. McArthur persuaded Sgt. Gauthier that Mr. McArthur had an honest but mistaken belief that the victim was consenting. Ms. Epstein concluded that it was premature for Sgt. Gauthier to draw this conclusion and suggested that the evidence did not support this conclusion. Sgt. Gauthier released Mr. McArthur without speaking to the victim about Mr. McArthur's account of the incident, even though there were serious conflicts in their statements. There was also no indication that Sgt. Gauthier took any steps to ascertain whether the victim consented to being choked, as required for the defence of honest but mistaken belief in consent to sexual assault.<sup>188</sup> The investigator was again unaware of Mr. McArthur's 2003 convictions or of Mr. McArthur's connections to three missing men. Mr. McArthur's 2003 convictions were not brought to the attention of investigators until 2017.

4. Andrew Kinsman, the one victim who was white, disappeared in June 2017. The investigation of his disappearance was done with commitment and skill, and the officers in this investigation showed sensitivity and compassion towards the affected families and communities. However, there were problems, including the failure to obtain videotape evidence showing Mr. Kinsman on the day of his last known sighting in a van connected to Mr. McArthur until almost two months after Mr. Kinsman's disappearance.
5. The investigators examining Andrew Kinsman's disappearance were initially unaware of Mr. McArthur's 2003 conviction for assault with a lead pipe. Once that came to light, the lead investigator felt he could not use that information in his investigation because it was dated and because Mr. McArthur had received a record suspension (pardon). Ms. Epstein concluded that the pardon did not prevent the police from using the information underlying the 2003 conviction.

The Report emphasized that some excellent work was done by officers and that some changes had already been made for the better. However, the Report identified serious flaws in the handling of missing persons cases in Toronto. There were suggestions that the Toronto police remained uninterested in the disappearances of the men of colour and only took the disappearances seriously once a white man went missing. Ms. Epstein concluded that there were a number of dedicated officers working tirelessly to solve the disappearances of those earlier cases, but the other victims were often given less attention or priority than they deserved. Some officers' stereotyping of LGBTQ2S+ communities impeded their work. Investigators failed to recognize or address the reality that the long history of mistrust of police by members of marginalized communities prevented some witnesses from coming forward.

The police failed to identify links between the missing persons cases in part because they did not use available search and linkage tools. They also failed to follow provincial standards for missing persons cases. For those cases that were identified as major cases, officers in charge were not always trained in major case management or the major case management software. Only a fraction of the information on the missing persons cases or on Project Houston (see below) was uploaded into that software, which was treated as a bureaucratic obligation rather than a case management system. The service had no centralized unit for examining all missing persons cases, no missing persons coordinator, and no dedicated missing persons case analyst. In

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<sup>188</sup> Sgt. Gauthier was charged under the Police Services Act of Ontario with insubordination and neglect of duty for his conduct with respect to this report. The Toronto Police Service's Disciplinary Hearings Office Tribunal acquitted him in August 2021. The hearing officer concluded that it had not been demonstrated that had Sgt. Gauthier complied with the policy for investigating domestic violence allegations, he could have formed reasonable grounds to charge Mr. McArthur. See M. Draaisma. 2021. "Police Officer Who Released Serial Killer Bruce Mr. McArthur in 2016 Cleared of Disciplinary Charges." *CBC News* (23 August 2021), <https://www.cbc.ca/news/canada/toronto/toronto-police-gauthier-not-guilty-bruce-mcarthur-1.6150748>. The Tribunal decision is not available online.

addition, almost all the investigations into Mr. McArthur's victims failed to comply with requirements to report to the Ontario Provincial Police (OPP) Violent Crime Linkage Analysis System (ViCLAS) unit. Many of the investigators did not understand or effectively use the tools to obtain internet profiles of the missing men.

### **Civilian Oversight**

Ms. Epstein concluded that effective civilian oversight of the police, including a well-informed police services board, is essential to ensuring governance and accountability. However, the Toronto Police Services Board was never made aware of the two projects, Project Houston and Project Prism, that the police undertook to investigate the missing men. Project Houston was also not compliant with provincial standards on major case management, which created significant risks. This noncompliance was flagged in an audit early in the stages of the Project, but the Board was never made aware of these concerns.

### **Coordination and Communication between Police Divisions and Agencies**

There was poor coordination between two TPS divisions investigating a single missing persons case. This contributed to the failure to locate the body of Tess Richey, a woman from the Village who went missing during this period, for several days. (Ms. Richey's death was not connected to the Mr. McArthur murders.)

Workload demands led to missing persons investigations being passed from officer to officer and being given lower priority than other cases. There were also serious problems with the quality of communication between the police, affected loved ones, and the Office of the Chief Coroner. Incomplete or inaccurate information was provided to the TPS about existing unidentified remains.

### **Resistance to the Idea of a Serial Killer**

There was strong institutional resistance to the notion that a serial killer may have been preying upon members of LGBTQ2S+ communities. By December 2017, there was strong circumstantial evidence that Mr. McArthur was involved in the disappearances of all five men who had connections to the Village and were known to be missing. The police were intensely focused on him. Yet TPS Chief Mark Saunders stated during a press conference on December 8, 2017 that "the evidence today tells us there is not a serial killer based on the evidence involved." Ms. Epstein concluded that Chief Saunders did not deliberately mislead the public, but the Report noted that his comments further harmed the relationship between the TPS and the affected communities, given that Mr. McArthur was identified as a serial killer shortly after the press conference.

### **Lack of a Public Warning**

In mid-July 2017, a superintendent suggested that the TPS issue a public safety media release warning gay men who were using dating sites to arrange sexual encounters of possible risk. The Director of Corporate Communications refused to issue the warning. The justification for this refusal was that it could cause the public to connect the disappearances under investigation with their use of dating sites, when that had not been established. No warning was issued until December 2017. Ms. Epstein referred to the *Jane Doe* case (see section 4.1. below) and commended the officers who suggested the warning. The Review did not fully explore the decision-making surrounding the warning, but Ms. Epstein made the point that public safety should trump other considerations. The fact that there was no established link between the dating sites and the disappearances should not have prevented the warning from being issued. Ms.

Epstein also expressed concern that Corporate Communications had the power to veto this warning over the wishes of the investigators involved in the case.

### **Systemic Discrimination**

Ms. Epstein did not conclude that the deficiencies in the Mr. McArthur-related investigations were caused by overt bias or intentional discrimination by individual officers. However, systemic discrimination was a factor. For example, the friends of Andrew Kinsman, a white man with a high profile in the LGBTQ2S+ community, fiercely advocated for a thorough investigation into his disappearance, and it was this advocacy that led to the creation of Project Prism and ultimately to Mr. McArthur's arrest. Mr. McArthur's other victims also had loved ones who wanted the police to investigate their disappearances with vigour, but those family and friends did not have the resources or connections to pressure the police effectively. "That differential treatment is unacceptable. The quality of a missing person investigation should not depend on who is best situated to demand the attention of the police."<sup>189</sup> The investigators' unfamiliarity with the LGBTQ2S+ communities and the victims' other communities was also a systemic contributor to the differential treatment of the victims. Another systemic problem was the focus on the personal problems of the victims, such as debt or mental illness, as explanations for their disappearances. "The police must remain vigilant to ensure that the potential victimization of marginalized and vulnerable missing persons not be obscured by overemphasis on those circumstances that make these persons marginalized and vulnerable in the first place."<sup>190</sup>

The historical and continuing criminalization of members of LGBTQ2S+ communities and other communities to which those members belong (such as immigrants, Black and Indigenous people, people with HIV/AIDs, and users of illegal drugs) also meant that going to the police is the last resort for many when they are in danger, for fear of being arrested or targeted themselves. Ms. Epstein referred to this as the "vicious circle of overpolicing and underprotection."<sup>191</sup>

### **Communication with the Public and Affected Communities**

The police did a poor job communicating with the public about their investigations and undervalued the affected communities' ability to assist in advancing the investigations. The police service's decision to keep Project Houston secret out of concern that transparency would harm the investigation "set the Service up for heightened mistrust when community members later learned they were misled... or, at a minimum, shut out. Inaccurate or unnecessarily censored statements by the Service and/or its senior command undermine respect for the Service and, ultimately, future investigations."<sup>192</sup>

Ms. Epstein stated that too much emphasis is placed on maintaining the integrity of police investigations. She said, "If affected communities do not trust the police because they feel the police do not trust them, investigations will inevitably suffer, and public confidence and support for the police will be eroded."<sup>193</sup> After Mr. McArthur's arrest, Chief Saunders also told the press

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<sup>189</sup> "Missing and Missed," volume I, p. 59.

<sup>190</sup> "Missing and Missed," volume I, p. 61.

<sup>191</sup> "Missing and Missed," volume I, p. 79.

<sup>192</sup> "Missing and Missed," volume I, p. 25.

<sup>193</sup> "Missing and Missed," volume I, p. 37.

that the investigation was well executed, which was clearly wrong. This too affected the affected communities' trust in the police.

Participants in the Civilian Review's community consultations viewed the TPS as "having a militaristic culture where conformity is valued over systemic change."<sup>194</sup> Oversight mechanisms were seen as largely ineffective, as demonstrated by the lack of discipline for officers who engage in discriminatory conduct and the lack of transparency over police discipline. Some participants advocated for mandatory training on issues relevant to the mandate of the Review, while others said training would have little effect on changing police culture.

The support given to those affected by the disappearances of Mr. McArthur's first three known victims was at best uneven. There were acts of kindness by individual officers, but support was not provided in a consistent or ongoing manner.

The Report commended the internal review of the TPS missing persons investigations and the resulting efforts to create an effective Missing Persons Unit. The Report identified a number of further improvements to be made. It noted that the trust between marginalized communities and police in Toronto had been so severely eroded that some suggested that "the situation is beyond repair" and that much of the work of the TPS should be transferred to new or other institutions. Ms. Epstein stated she was more optimistic, referring to "significant measures the Service has undertaken in recent years to address bias and discrimination in policing while acknowledging that much work must still be done to repair relationships."<sup>195</sup> She agreed that what is needed is "truly transformational change."<sup>196</sup>

Ms. Epstein recommended a number of measures to improve communication between the TPS and the affected communities, including:

1. the creation of a "missing person support worker" position, to be filled by civilians with experience and training in victim support and cultural sensitivity;
2. that promotions be tied to an officer's demonstrated ability to form and maintain relationships with vulnerable and marginalized communities;
3. changes to policies and practices governing communication with victim's loved ones, which would not give undue priority to preserving the integrity of an investigation and which would require a trauma-informed approach to the interviews of missing persons' loved ones; and
4. mechanisms to encourage reporting and information-sharing from members of communities who are fearful of communicating with the police, such as a "distance" reporting system that would designate trusted communities or agencies to transmit missing person reports or information from members of the community, without necessarily identifying the source.

## Training

Ms. Epstein noted that there had been more training and education on issues relevant to the mandate of the Review than community members realized. However, she noted that there had been no specialty training and education for missing person investigators. In addition to

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<sup>194</sup> "Missing and Missed," volume I, p. 54.

<sup>195</sup> "Missing and Missed," volume I, p. 80.

<sup>196</sup> "Missing and Missed," volume I, p. 86.

recommendations regarding specific training on missing persons investigations, Ms. Epstein recommended the following:

5. identification of measurable outcomes for training, and audits or other mechanisms to evaluate training effectiveness;
6. regular involvement of officers trained in major case management in major cases, so their training is not forgotten;
7. training on critical thinking, problem-solving, and empathy; and
8. the creation of a regional centre for policing excellence, housed within an academic institution.

### **Implementation of Recommendations**

The Review's terms of reference specifically required the identification of a framework for measuring, monitoring, and publicly reporting on whether the recommendations have been adopted, and where they have not been adopted, why; they also required the Review to ensure LGBTQ2S+ participation in the monitoring and implementation of recommendations. Ms. Epstein noted that "Recommendations for more training or greater diversity in policing ranks are important but of limited value. They no longer represent an adequate response to the issues this Review has identified."<sup>197</sup>

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 1) The Toronto Police Services Board and any future chief of police should publicly commit to the robust oversight by the Board recommended in the Independent Civilian Review into Matters Relating to the G20 Summit, conducted by the Hon. John W. Morden (June 2012).
2. (Recommendation 2) The Toronto Police Services Board should adopt a policy clearly defining the types of information that the chief of police should share with the Board, including what constitutes a "critical point." The policy should specify when and how those types of information should be shared. This policy should be prepared by the Board in consultation with the Toronto Police Service and as originally recommended in the Independent Civilian Review into Matters Relating to the G20 Summit.
3. (Recommendation 3) The policy outlined in Recommendation 2 should identify criteria that must be applied in determining when a "critical point" has been reached. At a minimum, such criteria should include:
  - a. a policing operation, event, or organizationally significant issue requiring command level approval (i.e., by the chief of police or deputy chief of police) or command level advance planning;
  - b. operations that may have a material impact on the Toronto Police Service's relationship with and servicing of marginalized and vulnerable communities, including those communities in which significant numbers of community members mistrust the police. These include racialized, Indigenous, LGBTQ2S+, homeless or underhoused, and others identified in this Report, as well as the intersection of these communities. Included here are operational decisions that may have a material impact on future relationships with these communities;

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<sup>197</sup> "Missing and Missed," volume I, p. 1.

- c. operations that may impact in a material way on the Service's reputation or its effectiveness;
  - d. operational matters, even ones involving an individual case, if they raise questions of public policy;
  - e. internal audits or analogous documents that identify systemic issues within the Service;
  - f. complaints against individual officers and the Service and findings about discrimination by other tribunals that raise systemic issues.
4. (Recommendation 4) The Toronto Police Service Board's "critical point" policy should also consider the non-exhaustive list Judge Sidney Linden set out in the 2007 Ipperwash Report of operational decisions that might require policy intervention by government. According to this list, an operational decision is one that may require some kind of policy intervention if it:
- a. requires unexpected financial or other resources;
  - b. could affect third parties or issues not directly involved in the situation/issues;
  - c. is necessary to vindicate or balance legal/democratic principles or rights with policing priorities and practices;
  - d. raises interjurisdictional issues;
  - e. could set a precedent for similar operational situations in the future;
  - f. requires intervention of higher levels of authority to resolve the operational issue;
  - g. must be made in a police or operational vacuum, where operational decision-makers do not have existing policies or protocols to guide them.
5. (Recommendation 5) The Toronto Chief of Police should establish corresponding procedures to the policies outlined in Recommendations 2 and 3 for sharing information with the Toronto Police Services Board.
6. (Recommendation 6) The Toronto Police Services Board should ensure that initial and ongoing training and education of its current and future members includes mandatory continual education not only on the role of the Board but on how it can be effective in its governance and oversight role. Emphasis should be on topics such as the sharing of information (including "critical points"), constructive dialogue with the Chief of Police, systemic issues to be explored, and the scope of and limitations to "directions" to the Chief of Police.
7. (Recommendation 7) The Toronto Police Services Board and the Toronto Police Service should ensure that initial and continual training and education of current and future chiefs of police, deputy chiefs, and senior officers should include what information should be provided to the chief of police and deputy chiefs to enable them to fulfill their responsibilities, including sharing information on "critical points," with the Board.
8. (Recommendation 8) The Toronto Chief of Police should establish procedures specifying what types of projects or operations have to be approved by senior command (see Recommendation 3(a)).
9. (Recommendation 9) [A] regulation permitting a chief of police to decline to provide information in accordance with a direction from a police services board is unnecessary, given the statutory prohibitions that already exist against inappropriate intervention by a board. The Toronto Police Services Board should urge the Ministry of the Solicitor General not to create such a regulation in the circumstances. If such a regulation is created, the scope for denying a board information about operations should be restricted, as it is, for example, in Victoria, Australia, to information whose disclosure would prejudice an investigation or prosecution or endanger the life or safety of a person.

10. (Recommendation 10) The Toronto Police Services Board should be allocated sufficient funding to ensure it can perform its extensive governance and oversight responsibilities under the Police Services Act and the new Community Safety and Policing Act 2019.
11. (Recommendation 11) The Toronto Police Services Board should re-examine all its existing policies as they pertain to the matters addressed in this Report and ensure that they provide meaningful policy direction to the Chief of Police and the Toronto Police Service, consistent with the recommendations made in this Report.
12. (Recommendation 12) The Toronto Police Service should commit itself through concrete measurable outcomes to complying with existing provincial adequacy standards respecting major case management and the use of PowerCase, the mandated case management software, for its intended purpose. Senior command must support and drive this commitment
13. (Recommendation 14) The Toronto Police Service and the Toronto Police Services Board should work in partnership with the Ministry of the Solicitor General and the Office of the Inspector General of Policing (once Part VII of the Community Safety and Policing Act 2019 is proclaimed) to support periodic independent monitoring of the Service's compliance with the provincial adequacy standards respecting major case management and the use of PowerCase.
14. (Recommendation 17) The Toronto Police Service's Chief Information Officer is currently reviewing the "interoperability of systems" and the software being used by the Service. Through expert assistance and having regard to the issues identified in this Report, this review should consider whether data must be loaded onto three separate systems (Versadex, a P Drive, and PowerCase) in major cases and, in any event, whether data can be uploaded in ways that reduce the time expended in this uploading. The review should also consider whether some of the current functions can be performed automatically.
15. (Recommendation 20) The Toronto Police Services Board and the Toronto Police Service should request that the Ministry of the Solicitor General revisit the need for province-wide compatible records management systems.
16. (Recommendation 21) The Toronto Police Service should ensure through its procedures that information collected during a major case is available on its records management system to other officers. This availability is subject to categories of information (such as that pertaining to confidential informants) that must or should be restricted.
17. (Recommendation 22) The Toronto Police Service should commit itself through concrete measurable outcomes to comply with existing provincial adequacy standards respecting ViCLAS submissions.
18. (Recommendation 23) The Toronto Police Service should ensure that its Audit and Quality Assurance Unit evaluates, on a regular basis until compliance is the norm, the extent to which the Service has become compliant with provincial adequacy standards respecting ViCLAS submissions.
19. (Recommendation 24) The Toronto Police Service should ensure that its Audit and Quality Assurance Unit's reports on ViCLAS compliance are provided to the Toronto Police Services Board.
20. (Recommendation 25) The Toronto Police Service and the Toronto Police Services Board should work in partnership with the Ministry of the Solicitor General and the Office of the Inspector General of Policing (once Part VII of the Community Safety and Policing Act 2019 is proclaimed) to support independent monitoring of the Service's compliance with the provincial adequacy standards respecting ViCLAS submissions.

21. (Recommendation 43) The Toronto Police Service should amend its Missing Persons procedures and practices in consultation with its own and external Victim Services agencies and relevant not-for-profit missing persons organizations to ensure that the following points are implemented.

- Information about an ongoing investigation is regularly provided to those directly affected by the disappearances of missing persons.
- The Service does not erect unnecessary barriers to providing such information based on an overly broad interpretation of what must be withheld to preserve the integrity of an investigation.
- Absent exceptional circumstances, a communication plan is created for every missing person investigation, in consultation with those directly affected, that includes
  - i. the name and contact information of the liaison person assigned to assist those directly affected, whether a missing person coordinator or a missing person support worker;
  - ii. the names and contact information of persons designated to be updated on the progress of the investigation;
  - iii. the frequency and type of information to be provided to the persons designated in the communication plan (e.g., the affected persons' wishes and schedule for contact, updates on the progress of the investigation, significant developments in the investigation);
  - iv. the type of information that is to be provided to the liaison person by the persons designated in the communication plan; and
  - v. the means by which information is to be provided.
- Generally, the directly affected persons are advised of details pertaining to the investigation that will be released to the media; they are given an opportunity to review and consent to any information or photos released to the media, unless these steps would jeopardize the investigation;
- Those interviewing directly affected persons use, where appropriate, a trauma-informed approach and are mindful of the ways in which the disappearance of a loved one may affect them. Interviewers should also be non-judgmental in their responses to a Missing Person Report and avoid appearing to blame the reporting individual for any delay in reporting.
- The Service's members have a clear understanding, based on human rights principles, of who represents a missing person's families, loved ones, or those directly affected and how they should communicate with them. This understanding means, among other things, that
  - the individuals who are to communicate with directly affected individuals are competent to ascertain those with whom they should be communicating;
  - they do so in a sensitive and appropriate way;
  - they are respectful of sexual orientation, gender identity and expression, and other relevant identifiers of the missing person and those directly affected; and
  - communication takes place, whenever possible, in the language of choice of those directly affected.
- Service members provide emotional or logistical support as may be needed to those directly affected or facilitate their access to other resources. Such support might include
  - contacting those directly affected on the anniversary of someone's disappearance and/or on other special dates, such as the missing person's

- birthday; such support, recommended in the National Centre of Missing Persons and Unidentified Remains Best Practices Guide, does a great deal to reassure those directly affected that the police have not forgotten about their loved ones; and
- working in partnership with social service, public health, victim-service, and community agencies and non-profit organizations, including relevant charities, to facilitate access to needed resources.
22. (Recommendation 44) The Toronto Police Service should develop, in partnership with diverse communities, a guide to missing person and unidentified remains investigations for those directly affected as well as the public at large.
23. (Recommendation 45) The Toronto Police Service should comply with the provincial adequacy standards respecting the assignment of a victim liaison officer to major cases, including missing person cases. The Service's procedures should be amended and/or a Routine Order issued to reinforce this requirement. In the context of missing person or bodily remains investigations, the victim liaison officer will generally be the missing person support worker or a missing person coordinator.
24. (Recommendation 46) The Toronto Police Service's Missing Persons Procedure should be amended to include the following requirement. In every missing person or unidentified remains case, the lead investigator or, in major cases, the major case manager should ensure that any support that has been or is being provided on an ongoing basis to those directly affected by an individual's disappearance is documented.
25. (Recommendation 48) The Toronto Police Service, in partnership with academic institutions and its own analysts, should continually work on developing the most sophisticated risk assessment tools. This work must include evaluating and testing the existing risk assessment tools with measurable outcomes to ensure they are evidence-based.
26. (Recommendation 49) Risk assessments should be done by those with specialized training and education in missing person investigations and risk assessment. Such experts should include, at a minimum, the members of the Missing Persons Unit and missing person coordinators, whether civilians or sworn officers.
27. (Recommendation 50) The Toronto Police Service should build capacity to have risk assessments performed in missing person cases 24/7 so they can be done as soon as practicable and promptly reviewed. It should also ensure that risk assessments are regularly re-evaluated as new information comes forward.
28. (Recommendation 51) The Toronto Police Service should ensure that the officials who conduct risk assessments meet regularly with each other and with non-policing agency partners to collaborate on current cases and to promote consistent approaches to assessments and quality control.
29. (Recommendation 52) The Toronto Police Service should develop, in partnership with social service, public health, and community agencies, a risk assessment-based triage protocol that enables appropriate cases to be diverted to non-policing agencies or addressed through a multidisciplinary approach, including referral to FOCUS tables.
30. (Recommendation 53) The Toronto Police Services Board and the Toronto Police Service should work with the City of Toronto, provincial and federal governments, and public health, social service, and community agencies to build capacity for non-policing agencies to share or assume responsibilities for missing person cases in ways consistent with the proposed mid-term and long-term models outlined in this Report.

31. (Recommendation 54) Risk assessments should identify and document:
1. the types of risks, if any, associated with a person's reported disappearance;
  2. existing factors that elevate or diminish these risks, while recognizing that a single factor that elevates risk may determine the level of response to a person's disappearance;
  3. the recommended investigative or other response to a person's reported disappearance;
  4. whether and to what extent the disappearance should be addressed by the police, social service, public health, or community agencies or through a multidisciplinary response, including but not limited to referral to a FOCUS table.
32. (Recommendation 55) In amending the current Risk Assessment forms, the Toronto Police Service should continue to design them to be user-friendly so as to enable types of risk and risk factors to be identified, with the ability to supplement them as needed.
33. (Recommendation 56) The Toronto Police Services Board and the Toronto Police Service, with their agency partners and the City of Toronto, should consider whether to create a dedicated missing person FOCUS table or dedicated FOCUS tables or to build added capacity more generally for FOCUS tables to enable them to play a more active role in missing person-related situations. If such a dedicated missing person FOCUS table or dedicated FOCUS tables are created, the Service and its partners should develop different but analogous criteria for intervention in missing person-related situations, based in part on the issues identified during this Review.
34. (Recommendation 57) The Toronto Police Services Board policies and the Toronto Police Service's Missing Persons Procedure and related Risk Assessment forms should be re-evaluated and upgraded in the light of the systemic issues identified by and the lessons learned through this Report. Explicit reference to the issues and lessons should be incorporated into these documents and/or into training and education. The list includes the following issues and lessons.
- In accordance with the National Centre of Missing Persons and Unidentified Remains Best Practices Guide, the need to treat missing person cases as presumptively high risk unless and until a risk assessment or available information reasonably supports an alternative approach.
  - The need to incorporate a clear definition of the "strong possibility of foul play," together with specific direction to address continuing misconceptions about when the strong possibility of foul play exists.
  - The need to provide direction, including lists on potential "red flags" of foul play or exposure to serious bodily harm, informed by the deficiencies identified in this Report.
  - In accordance with Recommendations 61–62, the need to provide further direction as to when missing person cases should be treated as major cases, whether or not mandated by provincial adequacy standards.
  - The need to provide clear direction and lists on the types of risks to be considered, apart from foul play, again informed by the deficiencies identified in this Report.
  - The need for risk assessments to be informed by the disproportionate number of marginalized and vulnerable people who go missing; by how those people are also disproportionately the victims of violence and criminal exploitation; and how, as a result, their marginalization and vulnerabilities may and often do elevate the risks associated with their disappearances; merely directing officers to determine whether missing persons are members of certain communities, without more information, is inadequate.

- The need to ensure that the fears and concerns of those who report someone missing or are directly affected by their disappearances are taken seriously, given their familiarity with the missing persons, and that their fears and concerns are not responded to in a dismissive or insensitive way.
  - The need to ensure that the affected communities' concerns—for example, about community safety and perceived patterns of disappearances or the possibility of a serial killer—are taken seriously and inform any investigative response.
  - On a related point, the need specifically to consider patterns of disappearances, where potentially correlated, as part of a risk assessment, rather than focusing exclusively on a single disappearance.
  - The need to avoid a mindset that unreasonably discounts the possibility of foul play or serious bodily harm.
  - Similarly, the need to ensure that risk assessments are not based on institutional or systemic reluctance to elevate the risk assessment because of extraneous concerns about resource implications.
  - As partially reflected in the Service's current Missing Persons Procedure, the need to ensure that risk assessments are not based on or influenced by stereotypical assumptions or misconceptions about missing persons with certain personal identifiers, such as sexual orientation, gender identity, and gender expression, or missing persons who have certain perceived or actual lifestyles. In this regard, examples of such stereotypical assumptions or misconceptions should be informed by this Report.
  - The need to ensure that risk assessors are provided direction or guidance not only on the questions to be asked but also on how the answers bear on risk.
  - Though not currently articulated in the Service's Missing Persons Procedure, the need to ensure that the contents of Missing Person questionnaires are used in making risk assessments.
  - The need to ensure that risk assessors are provided examples of scenarios that elevate or reduce risk.
  - The need to ensure that clear direction is provided as to the need constantly to re-evaluate risk as an investigation progresses. When and if a lead investigator or major case manager is assigned, this ongoing re-evaluation should take place collaboratively with these officers.
35. (Recommendation 60) The Toronto Police Services Board and the Toronto Police Service should support continuing research on risk assessment, including the creation of predictive models, based in part on disaggregated data collected by the Service and on analytical work.
36. (Recommendation 65) The Toronto Police Service's procedure that defines which division or service investigates a missing person case is outdated and, in partnership with the Ministry of the Solicitor General, should be revisited. Among other things, revised procedures should be informed by the following considerations:
- Where the police reasonably believe that the focus of the investigation will largely although perhaps not exclusively be within the jurisdiction where the person was last seen (if known), and the investigation is not to be conducted by the Missing Persons Unit, it should generally be conducted by the division where the person was last seen. This approach is subject to a determination by the Missing Persons Unit that the particular circumstances warrant a different approach.
  - In the above circumstances, where the missing person resides in the jurisdiction of another police service, the relevant police services should liaise with each other to determine jointly the most appropriate service to lead the investigation. That

- determination should be documented and should be made based on where the investigation would most effectively be conducted rather than on extraneous considerations.
- Where more than one division or service must perform the actual investigative work, efforts should be made to avoid duplication and other inefficiencies. There should be clear lines of reporting and coordination, and in cases involving more than one police service, the province should create a process for facilitating these investigations, even if they do not meet the criteria for multi-jurisdictional joint investigation.
37. (Recommendation 66) The Toronto Police Services Board and the Toronto Police Service should urge the Ministry of the Solicitor General to adopt province-wide guidelines on jurisdiction to be exercised in missing person and unidentified remains investigations. Consideration should be given to the National Centre of Missing Persons and Unidentified Remains Best Practices Guide respecting jurisdiction; the guide treats the place a missing person is last seen (if known) as the lead criterion for assuming jurisdiction.
38. (Recommendation 69) The Toronto Police Service should amend its Missing Persons Procedure to ensure full continuity in missing person investigations when lead investigators go off-shift. Such continuity means
- investigations should continue even in the absence of the lead investigator;
  - an officer assumes carriage of the investigation in the lead investigator's absence; and
  - changes in the identity of the lead investigator are documented in the investigative file and made known to those closely associated with the missing person's disappearance.
39. (Recommendation 70) The Toronto Police Service should amend its Missing Persons Procedure to ensure full continuity in missing person investigations when lead investigators are reassigned or retire. Such continuity means
1. the investigation should be reassigned promptly;
  2. the reassignment should be documented in the investigative file and made known to those closely associated with the missing person's disappearance; and
  3. when feasible, the former lead investigator should take steps to familiarize the new lead investigator with the investigation and document the fact that this step has been taken.
40. (Recommendation 71) The Missing Persons Unit or, on adoption of the mid-term model proposed in this Report, missing person coordinators should assume responsibility for continuity and consistency of file management. Missing person coordinators should have lines of reporting within their division or quadrant as well as to the head of the Missing Persons Unit.
41. (Recommendation 72) The Toronto Police Service should amend its applicable procedures, in accordance with the recommendation contained in the 2019 116 Independent Civilian Review into Missing Person Investigations Inspection Report of the Ministry of the Solicitor General, to require
1. the officers assuming the responsibilities of the command triad in major cases to be clearly identified, and
  2. the assigned officers in missing person and unidentified remains investigations, or the officers who assume the responsibilities of the assigned officers in their absence, to be easily accessible to the public, most particularly those closely associated with the missing persons or, potentially, to the unidentified remains.

42. (Recommendation 73) The assignment of investigators or interviewers to a missing person investigation should be informed by their individual skills and competencies. In making such assignments, supervisors should be mindful of and informed by the dynamics in individual cases. These dynamics may include (a) the nature of the investigation; and (b) the personal identifiers relevant to the missing person, those who report that person missing, or those being interviewed.
43. (Recommendation 74) The Toronto Police Service should strengthen its existing Missing Persons Procedure to ensure that the investigators make themselves aware of existing community resources that can advance their missing person investigations and fully use those resources as needed. The Service should work proactively with community groups and leaders to establish processes for community partnership and engagement in missing person investigations.
44. (Recommendation 75) The Toronto Police Services Board and the Toronto Police Service should develop, in partnership with community groups and leaders, an information-sharing strategy that institutionalizes ongoing communication with community leaders and groups and with the public at large about the Service's missing person investigations. The information-sharing strategy should draw upon the systemic issues this Review identifies and the related lessons learned. In particular, the strategy should promote:
1. Information-sharing about specific investigations with affected communities and the public at large;
  2. community partnership in how and what information is shared, including use of community resources for messaging;
  3. a process for decision-making around public warnings that includes, to the extent possible, confidential input from community leaders or groups;
  4. police participation in community meetings and town halls, both to inform communities about existing missing person processes and specific investigations of concern to those communities and to address potential barriers to information-sharing;
  5. ongoing feedback from communities about the Service's successes or failures in its communication strategy and, more generally, in its ongoing relationships with diverse communities;
  6. consideration of the impact on marginalized and vulnerable or disadvantaged communities in failing to communicate information;
  7. the development of a user-friendly missing person and unidentified remains webpage;
  8. the development of a coherent and comprehensive approach to the use of posters and both social and traditional media to share information;
  9. recognition that not every community member has equal access to the internet or electronic communication, as well as the need to address linguistic barriers, and to accommodate those with disabilities; and
  10. the creation of missing person awareness days.
45. (Recommendation 77) The Toronto Police Service should amend its procedures relating to both missing person and unidentified remains investigations to ensure that, where appropriate, timely media releases are issued in relation to such investigations.
46. (Recommendation 81) The Toronto Police Service should re-evaluate its existing decision-making processes for issuing public safety warnings. At a minimum, in relation to major case investigations, the major case manager should make the ultimate decision, in consultation with the Service's Corporate Communications, as to whether a public safety warning is required. These types of decisions should be made whenever possible in partnership or in consultation with community leaders.

47. (Recommendation 83a) The Toronto Police Service should fully use its liaison officers and its neighbourhood community officers to advance missing person and unidentified remains investigations.
48. (Recommendation 83b) The Toronto Police Service should revise its Missing Persons Procedure, as well as relevant job descriptions, to explicitly recognize that its liaison and neighbourhood community officers may
- ii. facilitate information being made available, particularly from marginalized and vulnerable community members otherwise reluctant to come forward;
  - iii. create a safe and welcoming environment for those who want to report a person missing and for potential witnesses who want to come forward;
  - iv. dispel existing mistrust and provide needed assurances;
  - v. familiarize investigators with the significance of information they are being provided;
  - vi. correct stereotypical assumptions or preconceptions that can infect investigations;
  - vii. access street-level community members otherwise inaccessible to investigators, who may be well situated to assist an investigation;
  - viii. address concerns about the potential misuse of information provided to police, including privacy issues around sexual orientation, gender expression, or identity; and
  - ix. ensure that appropriate language is employed in media releases and by investigators in their interactions with community members.
49. (Recommendation 91) The Toronto Police Service should amend its procedures, including the Missing Persons Procedure, and disseminate a Routine Order to address the systemic issue represented by the Service's failure to respond to the attempts of another police service to interest the Service in a potentially connected investigation. More specifically, the procedures should require that a Toronto police officer advised of a potential connection between a case in Toronto and another jurisdiction document the information provided and ensure that it is followed up on, and that the follow-up is documented in the relevant investigative file.
50. (Recommendation 92) The Toronto Police Services Board and the Service should request that the Ministry of the Solicitor General draw the issue of lack of communication between services to all Ontario police services and identify a contact person (or position) at the Ministry in the event that any officer or service is concerned about the failure to respond appropriately to such information being communicated.
51. (Recommendation 96) The Toronto Police Service should amend its Missing Person Procedure to address in a more helpful and thorough fashion the need to interview key witnesses pertaining to the report of a missing person and the subsequent investigation.
52. (Recommendation 103) The Toronto Police Service should evaluate the continuing use of officer memobooks, having regard to the issues identified during this Review.
53. (Recommendation 104) The Toronto Police Service should reinforce, through its procedures and Routine Orders, that all memobooks are Service property and must be retained as its property. All memobooks relating to specific investigations must be preserved in the investigative files pertaining to those investigations.
54. (Recommendation 109) The Toronto Police Service should commit itself to the professional use of multidisciplinary case reviews or case conferences, as contemplated by the Major Case Management Manual, to evaluate investigations objectively and thoroughly. In some circumstances, as is the case in the United Kingdom, serious issues in the conduct of an investigation should lead to an independent review accompanied by a public report. This

recommendation calls upon the Service to be far more introspective about its own failings and to correct them.

55. (Recommendation 110) The Toronto Police Service should evaluate whether existing supervision and oversight of major investigations should be reexamined. This evaluation involves a more fundamental and introspective questioning of the lines of supervision within the Service and whether they are serving its needs.
56. (Recommendation 111) The Toronto Police Services Board and the Toronto Police Service should re-evaluate, in partnership with the City of Toronto, what protections currently exist for those with precarious legal status who wish to report people missing or provide information about them; whether the Service has misinterpreted its existing enforcement obligations, particularly under immigration legislation; and whether its current procedures and practices are consistent with the city's sanctuary city policy and related directions. This re-evaluation, supported by an independent legal opinion, should lead to enhanced, well-communicated protections that will assist in reducing barriers to reporting or information-sharing with the police.
57. (Recommendation 112) The Toronto Police Service should consider incorporating into its Missing Persons Procedure a third-party or "distance" reporting system (where trusted community leaders, organizations, or agencies are designated to transmit, anonymously if necessary, missing person reports or information to the police).
58. (Recommendation 113) The Toronto Police Service and the Toronto Police Services Board should consider whether they wish to acknowledge the deficiencies identified in this Report, together with the adverse impact they have had on those communities and individuals directly affected. Such an acknowledgement should be made only if heartfelt, if it is accompanied by a detailed action plan for change that is subject to independent monitoring, and if the content of the acknowledgement and the action plan is developed in partnership with communities. Any such acknowledgement should form part of a comprehensive reevaluation by the Service and the Board of the urgent need to improve relationships with Toronto's diverse communities, including those who suffer intersecting and overlapping grounds of systemic discrimination and disadvantage.
59. (Recommendation 114) The Toronto Police Service should consider whether to acknowledge the problems associated with Chief Saunders's statements on December 8, 2017 and later to the Globe and Mail and how they contributed to the elevated mistrust that followed the McArthur-related investigations.
60. (Recommendation 115) The Toronto Police Services Board and the Toronto Police Service should reflect in their recruitment policies the following standards:
  1. recruits must have a minimum of 30 credits of post-secondary education (or such higher minimum as the Board and Service might determine);
  2. post-secondary education need not include policing-related courses but may well include courses that promote communication, problem-solving, and relationship-building skills and cultural understanding and humility; and
  3. diversity and equity in hiring continue to be supported.
61. (Recommendation 116) The Toronto Police Services Board and the Toronto Police Service should commit the Service to becoming a recognized national if not global leader in police training, education, and professional development both for recruits and the Service's sworn officers and for its civilian employees, with particular emphasis on those who perform functions relevant to this Review's mandate, such as community engagement, equity, inclusion, and human rights.

62. (Recommendation 117) The systemic issues identified by and lessons learned during this Review should inform the content of the training and education of the Toronto Police Service on the following topics:

- ii. risk assessment in missing person cases;
- iii. the use of technology to advance investigations and the importance of such use;
- iv. the use of existing internal resources and community partnerships to advance investigations involving diverse marginalized and vulnerable communities;
- v. communication strategies to ensure that investigations are to the fullest extent possible transparent;
- vi. interviewing techniques and appropriate preparation for interviews, including the nature and scope of work-ups for interviewees;
- vii. trauma-informed interview techniques for those emotionally traumatized by a disappearance or the discovery of a deceased person;
- viii. how and when to effectively access relevant electronic information, the internet, and social media personally, through the assistance of the Technological Crime Unit or the Cyber Crime Unit, or through legal process;
- ix. how and when to utilize the Missing Persons Act, 2018;
- x. how to determine whether a case meets the criteria for a major case, whether threshold or non-threshold, and what the designation as a major case means;
- xi. major case management and the use of PowerCase;
- xii. when the Homicide Unit should be advised that bodies or unidentified remains have been found;
- xiii. when the Homicide Unit should be consulted or engaged in relation to a missing person investigation;
- xiv. tunnel vision;
- xv. what is and is not available to officers on the Service's records management systems;
- xvi. the uses that can and cannot be made of underlying conduct relating to a record suspension (previously known as a pardon) for investigative purposes;
- xvii. the role of the Emergency Management and Public Order search managers and unit members insofar as they relate to urban canvassing and searching, and how they can be called upon to assist in missing person investigations; and
- xviii. the criteria that define when missing person investigations become major cases subject to major case management, as well as how to interpret those criteria.

63. (Recommendation 118) The Toronto Police Service should develop specialized training and education on missing persons and unidentified remains investigations. Such specialized training and education should:

- a. be made available at a minimum to those who become members of the Missing Persons Unit, including the analyst and missing person support workers, all missing person coordinators, those who are expected to serve as lead investigators in missing person or unidentified remains investigations of any complexity, and supervisors expected to review risk assessments in missing person cases. The Service is best situated to decide how such training and education should be integrated into either the existing or any new training and education regime.
- b. be informed in part by the systemic issues identified during this Review and the lessons learned as a result, as well as the objectives of the strategic plan outlined above. Examples of the content of such training and education would include:

- i. how to respond to, and take seriously, the concerns expressed by community members or those directly affected when someone has gone missing. It undermines confidence in the police for officers to minimize or dismiss, whether or not well-intentioned, the concerns expressed about a missing person;
  - ii. the heightened risks that are associated with marginalized and vulnerable groups and how that should inform an investigation;
  - iii. the availability of internal and community resources to assist in overcoming barriers to obtaining relevant information from marginalized and vulnerable community members in a safe environment, and “red flags” associated with possible foul play or factors that elevate risk of serious bodily harm or victimization.
64. (Recommendation 120a) The Toronto Police Service should place much greater emphasis on continuing education for its members that addresses reasoning and problem-solving skills, empathy and understanding, and cultural humility.
65. (Recommendation 120b) The Toronto Police Service should partner with those who work with marginalized and vulnerable communities and community members to design and provide mandatory social context education that can, where possible, be integrated into all forms of training and education. Social context education would include:
  - the history of the Service’s relationship with the LGBTQ2S+ communities, and marginalized and vulnerable communities generally, and how that history should inform policing;
  - the diversity of Toronto’s communities, including its most marginalized and vulnerable members and the concept of intersectionality and its importance to policing; and
  - where possible, experiential, interactive, and place-based learning, which could include land-based learning about Indigenous people and placements with community agencies that work with marginalized and vulnerable groups.
66. (Recommendation 121) The Toronto Police Service should place much greater emphasis on evaluating the effectiveness of training and education through measurable outcomes. This emphasis might be reflected, for example, in auditing the extent to which officers have incorporated their training and education on discrimination-free policing into their interactions with community members.
67. (Recommendation 122) The Toronto Police Services Board and the Toronto Police Service should to a significant degree, through policy and procedures, link promotions to demonstrable competency in developing and sustaining community relationships, particularly with marginalized and vulnerable communities. The evaluation of such competencies can be based on prior activities, community support, and/or responses to case scenarios that raise issues around engagement with such communities.
68. (Recommendation 123) The Toronto Police Services Board and the Toronto Police Service should support the creation of a regional centre for policing excellence, housed within an academic institution. The centre would, through research and ongoing evaluation, promote excellence in policing through developing best practices on policing, including training, education, and professional development; itself provide some leadership training and education for senior officers and board members; offer “training the trainers” or “educating the educators” programming; create an environment for policing to be regarded as a profession; and, based on the research produced, recommend evidence-based statutory or regulatory changes. Ideally, the Centre would also be established in partnership with other regional police services and police services boards, the Ministry of the Solicitor General, and the Office

of the Inspector General of Policing, and community, private sector, and not-for-profit stakeholders.

69. (Recommendation 124) The Toronto Police Service should publicize, at a minimum on its website, the mandatory and optional programming provided to its employees. Community members are often uninformed about the programming that is currently offered. Such transparency is also consistent with the treatment of policing as a profession.
70. (Recommendation 125) The Toronto Police Services Board and the Toronto Police Service should proactively explore additional partnerships with academic institutions to promote independent research on policing and on the systemic issues and research deficits identified in this Report.
71. (Recommendation 126) The Toronto Police Service should consider introducing recently developed psychological testing in hiring and recruiting in order to assist in eliminating applicants who have discriminatory views and attitudes.
72. (Recommendation 127) The Toronto Police Services Board and the Toronto Police Service should ensure that the Service develops a robust equity plan as soon as practicable. Whether included in the Service's equity plan or in an "equity framework" that guides the Service's internal operations and external relations, or both, such documents should, among other things,
  - i. facilitate the use of an "inclusion lens" whenever the Service creates or amends procedures and practices,
  - ii. develop a tool for decision-making that considers the impact of procedures and practices on marginalized and vulnerable communities and on Toronto's diverse communities more generally,
  - iii. create a mechanism to ensure that the Equity, Inclusion and Human Rights Unit and the Community, Partnership and Engagement Unit play important roles in evaluating the Service's procedures and practices, insofar as they impact marginalized and vulnerable communities, and diverse communities generally,
  - iv. develop equity-based management strategies to embed equity, inclusion, and human rights throughout the organization, so that senior command and supervisors are responsible and held accountable for ensuring that equitable and inclusive practices are ingrained in their work and in the work of those they supervise. The Equity, Inclusion and Human Rights Unit should play a key role in developing, implementing, and evaluating equity-based management strategies, in consultation with a variety of stakeholders within and outside the Service, such as the Service's Internal Support Networks, and
  - v. explicitly recognize the important connection between equity within the Service and equity in the Service's interactions with the diverse communities it serves.
73. (Recommendation 128) The Toronto Police Services Board and the Toronto Police Service should consider whether the critical goal of advancing equity would be enhanced by merging or placing the Service's two units devoted to equity under the same chain of command. These units are the Equity, Inclusion and Human Rights Unit and the Community Partnership and Engagement Unit. The assignment of Toronto's senior officers to equity portfolios, as has been done, represents an important step in implementing this part of the recommendation.
74. (Recommendation 129) The Toronto Police Service should develop additional mechanisms to measure how community members, particularly members of marginalized and vulnerable communities, feel about their interactions with the Service. Such mechanisms might include equity audits of divisions or specialty units, through surveys, focus groups, and analytics, to

determine how many people interacted with the Toronto police, how those people self-identify, and whether they felt they were treated in a respectful fashion. The audits should be designed to enable community members to provide their perspectives in a safe and confidential environment. Respondents should feel able to include suggestions for change and what worked well or poorly in their interactions with police.

75. (Recommendation 130) The Toronto Police Services Board and the Toronto Police Service should ensure that the Service's Equity, Inclusion and Human Rights Unit is adequately resourced to facilitate implementation of the recommendations respecting bias and discrimination contained in this Report and to build competencies within the unit to engage with LGBQ2S+, trans, racialized, and Indigenous communities.
76. (Recommendation 131) The Toronto Police Services Board and the Toronto Police Service should ensure that the Service's Wellness Unit is adequately resourced to build competencies within the unit to provide culturally specific wellness resources and support to diverse members of the Service.
77. (Recommendation 132) The Toronto Police Services Board and the Toronto Police Service should take steps through a strategic plan or strategy to address issues around transparency and accountability in how conduct by the Service's members is addressed that raise concerns about discrimination, including harassment, and differential treatment based on human-rights personal identifiers. This recommendation applies regardless of whether the conduct raises concerns about discrimination against the Service's members or against members of the public. Such steps should include, at a minimum:
- vi. timely and transparent identification by the Service of complaints that raise concerns about discrimination, whether overt or intentional or systemic;
  - vii. timely and transparent identification by the Service of findings by courts or tribunals that raise concerns about discrimination;
  - viii. the creation or amendment of policies and procedures to provide for a consistent, comprehensive, and transparent strategy for dealing with these cases;
  - ix. involvement of the Equity, Human Rights and Inclusion Unit in developing and implementing such a strategy, advising the Professional Standards Unit, and monitoring compliance with relevant policies and procedures;
  - x. consideration of the enhanced role that marginalized and vulnerable communities that are the subject of discrimination can play in the investigative, resolution, and disciplinary processes, including feedback on resolution and community victim statements to be filed with the discipline tribunal, consistent with existing legislation and procedural and substantive fairness to those accused of misconduct; and
  - xi. regular reporting to the Board on implementation of the strategic plan or strategy, consistent with the role of the Board as described above.
78. (Recommendation 133a) The Toronto Police Services Board and the Toronto Police Service should ensure that Service-related disciplinary decisions (in addition to those appealed to the Ontario Civilian Police Commission) are easily accessible to and searchable by the public and/or indexed for the public's use. Lack of transparency in decision-making contributes to mistrust, particularly on the part of marginalized and vulnerable communities. It also undermines accountability of the Toronto Police Service for how discipline is being addressed.
79. (Recommendation 133b) The Toronto Police Services Board and the Toronto Police Service should also urge the Minister of community safety and correctional services to make regulations, pursuant to s. 148(2) of the Community Safety and Policing Act 2019, as yet unproclaimed, to ensure that all the decisions from adjudication hearings under the Act are published on the Internet and easily searchable.

80. (Recommendation 134) The Toronto Police Services Board and the Toronto Police Service should facilitate, preferably together with the Ministry of the Solicitor General and the Office of the Inspector General of Policing, the publication of the ability of any person to make complaints under s. 107 of the Community Safety and Policing Act 2019.

81. (Recommendation 135) In the light of the issues this Report identifies, the Toronto Police Services Board and the Toronto Police Service should re-evaluate and rationalize, in partnership with the diverse communities they serve, the ways in which community consultation takes place, especially in relation to marginalized and vulnerable communities. In particular, they should take into consideration these points:

- The need to ensure that the intersecting requirements of Toronto’s marginalized and vulnerable communities are fully addressed in the consultative process and that intersectionality should figure centrally in how the consultative process takes place. These goals might be accomplished through a process modelled on Seattle’s Community Police Commission; a process whereby existing committees regularly interact and share information on common issues; and/or a process that ensures that intersectionality forms part of the selection criteria for each committee. The process might also involve greater inclusiveness to ensure that marginalized and vulnerable groups, such as the homeless and sex workers, are heard.
- The need to avoid unnecessarily duplicative consultations that result in consultation fatigue, unwise use of limited human and financial resources, and diluted or unclear messaging from communities.
- The need to ensure that the Board is able to provide appropriate civilian oversight of the Service, in part through reducing or eliminating the divide between community consultations with the Board and the Service. The Board must always be aware of “critical points” that may affect its policies and the Service’s reputation.
- The need to rationalize how communities that are spread throughout the city and those that are located in particular geographic sectors are consulted in relation to both city-wide and local divisional issues, while avoiding unnecessarily duplicative consultations.
- The need to ensure that the consultative processes of the Service and the Board complement the development of the city’s community safety and well-being plan and related consultations.
- The need to build community confidence in the consultative process through measures such as
  - i. transparency in how committee members are selected (for example, through an advertised search);
  - ii. outreach to those not regarded as “pro-police”;
  - iii. facilitating participation by those most marginalized and vulnerable through the provision of remuneration and/or accommodation;
  - iv. holding meetings in community spaces;
  - v. holding meetings in some instances in public;
  - vi. the ability and independence of committees to report publicly and to offer recommendations or commentary; and
  - vii. the ability of senior officers to participate in community consultative committees as members or invitees, but not as co-chairs.
- The need to promote an effective consultation process through measures, in addition to those set out above, such as
  - i. fixed, renewable terms for committee members;
  - ii. appropriate administrative and research support;
  - iii. regular setting of goals, with measurable outcomes;

- iv. a credible evaluation process; and
- v. a web and social media presence.

The Board and the Service might also consider, in this regard, features of the model for community policing committees proposed by the Commission on Systemic Racism in the Justice System.<sup>198</sup>

82. (Recommendation 136) The Toronto Police Services Board and the Toronto Police Service should develop a strategy specifically directed to communicating effectively with the public, particularly diverse communities, about what they are doing. This strategy should include the following:

- i. The initiatives the Board and the Service are making to build relationships, and independent evaluations of these initiatives should be well publicized in a variety of ways.
- ii. Greater use should be made of town halls, which the Board has recently organized effectively, as well as interactive small-group discussions in community spaces.
- iii. The Service’s website should be completely redesigned (over and above the missing person webpage) to be truly user-friendly, having the users’ needs foremost in mind, and to overcome barriers such as language and accessibility.
- iv. Full-time and part-time liaison officers should have a greater social media presence.

83. (Recommendation 137) The Toronto Police Services Board and the Toronto Police Service should support and significantly enhance the liaison officer program in the following ways:

- v. increasing the number of liaison positions consistent with the full range of responsibilities this Report proposes and the critical importance of building relationships with Toronto’s marginalized and vulnerable communities;
- vi. using a combination of sworn officers and civilian members of the Service to fill additional liaison positions;
- vii. including a cadre of part-time liaison positions at the divisional level within a strategy to embed relationship-building into all aspects of policing in Toronto;
- viii. providing enhanced training, education, and professional development for full-time and part-time liaison officers and civilian members of the Service, to ensure that they can address issues of intersectionality through familiarity with a range of intersecting marginalized and vulnerable communities;
- ix. developing additional strategies to enable liaison officers and civilian members of the Service to potentially serve multiple marginalized and vulnerable communities, including team approaches to intersecting communities;
- x. regularly reallocating liaison resources to address evidence-based needs—for example, assigning several liaison officers and/or civilian members of the Service to address the needs of a particular community or communities otherwise underserved by the program, such as the homeless or the underhoused;
- xi. expanding the Aboriginal Peacekeeping Unit and/or the current complement of a single liaison officer dedicated to the Indigenous communities. The current complement is inconsistent with existing Board policy and the priorities identified in the Community Safety and Policing Act 2019 (SO 2019, c 1, Schedule 1, not yet proclaimed);

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<sup>198</sup>The Report of the Commission on Systemic Racism in the Justice System (Toronto, Queen’s Printer: 1995) recommended community policing committees which would be appointed and supported by police services boards. These committees would hold public meetings and develop policing objectives to be considered by the boards and police services. They are described in “Missing and Missed,” volume II, p. 844.

- xii. providing analytic support for the liaison program to enable it to allocate resources appropriately;
  - xiii. explicitly recognizing in the mandate and job descriptions relating to the liaison program, the responsibilities articulated in this Report over and above the current duties of liaison officers, including:
    - the responsibilities set out in Recommendation 56;
    - participation in equity-related issues within the Service, such as responding to internal discrimination or harassment that may affect the Service's ability to build better relationships;
    - assisting, where appropriate, in remedial or restorative measures associated with informal discipline;
    - assisting in designing and participating in the training and education of Service members and part-time liaison officers or civilian liaison members of the Service relating to the lived experiences of intersecting marginalized and vulnerable communities; and
    - in partnership with communities, assisting the Service in designing and offering training, education, and professional development relating to marginalized and vulnerable communities; in building relationships with such communities; and in identifying for investigators resources inside and outside the Service to advance investigations relating to these communities; this training, education, and professional development, some of which the current liaison officers are involved in, would also be provided to part-time liaison officers and civilian liaison officers.
84. (Recommendation 138) The Toronto Police Service should create part-time liaison positions in each division composed of officers and/or civilian members of the Service who receive special training and education in relation to their duties. Their responsibilities should be similar to those of full-time liaison members of the Service, with appropriate modifications to reflect their part-time status. They should also work with full-time liaison officers or civilian members of the Service on issues that arise at the divisional level.
85. (Recommendation 139) The Toronto Police Service should enable liaison officers, civilian liaison members, and neighbourhood community officers to spend modest amounts to promote relationship-building with marginalized and vulnerable communities. The Service should reimburse expenses that have been approved.
86. (Recommendation 140) The Toronto Police Service should arrange for an independent evaluation of the liaison program within a reasonable timeframe after modifications of the program have been introduced. The independent evaluation should assist the program in identifying underserved marginalized and vulnerable communities and reallocate resources commensurately. Such an evaluation should be made public.
87. (Recommendation 141) The Toronto Police Services Board and the Toronto Police Service should continue to support and expand the Neighbourhood Community Officer Program as an effective means of promoting community safety while also building relationships with marginalized and vulnerable communities.
88. (Recommendation 142) The LGBTQ2S+ and other internal support networks should be recognized as important assets in community engagement and in the Service itself. Network members, either individually or collectively, should participate in community outreach and other activities that serve their communities. Allowing the support networks to play an external role may help inform the public, the Toronto Police Services Board, and the Toronto Police Service of the problems confronted by minority groups within the Service and also advise

them of reforms these officers propose based on their lived experiences. This approach will also contribute to a positive change in culture within the Service and signal greater support for the Service's own vulnerable members.

89. (Recommendation 143) The Toronto Police Services Board and the Toronto Police Service, in consultation with Toronto's Indigenous communities and agencies providing services to them, should develop a formal response to the call to action from the National Inquiry into Missing and Murdered Indigenous Women and Girls (see the summary in section 6.2.7. below).
90. (Recommendation 144) The Toronto Police Services Board and the Toronto Police Service, in order to improve relationships with marginalized and vulnerable communities and the groups that represent them, should recognize that such groups have expert knowledge, networks, and skills that the Board and the Service cannot replicate easily or cost effectively. They should consider partnerships with community agencies that can help fund promising community safety initiatives such as the Bear Clan and SAFE. They should also encourage research into the effectiveness of such community programs, with attention to having clearly articulated goals, gathering baseline statistics, and measuring the success of these programs in both quantitative and qualitative terms, as well as to identifying any improvements that can be made in them.
91. (Recommendation 146a) On or before June 30, 2021, an implementation team comprised of a diverse team of community representatives and Service members should be assembled. This team should be responsible for developing an implementation plan, to be modified as circumstances warrant, and for monitoring and reporting on progress in implementation.
92. (Recommendation 146b) The implementation team should be co-led by a community representative and a past or present member of the Service's senior command.
93. (Recommendation 146c) The implementation team's community members should be representative of the diversity of Toronto's communities, with appropriate attention given to the LGBTQ2S+ and marginalized and vulnerable communities addressed in this Report.
94. (Recommendation 146d) The implementation team may create subgroups with subject matter expertise and/or relevant lived experiences, although the team should always remain mindful of the significance of intersectionality in defining expertise and relevant lived experiences.
95. (Recommendation 146e) The community members should ideally include some individuals who have already acquired knowledge of the issues this Report identifies, either as members of the advisory group that recommended this Review and drafted its Terms of Reference or as members of the Review's Community Advisory Group.
96. (Recommendation 146f) The policing members should ideally include members of the Service's Missing Persons Unit Procedures Working Group.
97. (Recommendation 146g) Community members should be remunerated for their participation as members of the implementation team.
98. (Recommendation 147a) On or before September 30, 2021, the implementation team should complete its implementation plan and post it on the Toronto Police Service's website or some other suitable venue. The plan should specify goals, timelines, and measurable outcomes.
99. (Recommendation 147b) The implementation team should issue progress reports at least once a quarter that should be posted on the Toronto Police Service's website or some other suitable venue. The first progress report should be issued no later than December 31, 2021. The team might also consider the use of an online tracking tool for implementation, as has been used by the City of Toronto.

100. (Recommendation 148) On or before April 30, 2022, the Toronto Police Services Board and the Toronto Police Service should publicly release a detailed report on the extent to which each recommendation has been implemented. If the Board and/or the Service decides that a particular recommendation should not be implemented or be delayed or modified, the report should set out why this decision has been made and how the underlying objectives of the recommendation are being met in another way.
101. (Recommendation 149) When Part VII of the Community Safety and Policing Act 2019 is proclaimed, the Toronto Police Services Board and the Toronto Police Service should support the role to be played by the Office of the Inspector General of Policing in independently monitoring the implementation of this Report's recommendations.
102. (Recommendation 150) The Toronto Police Services Board, the Toronto Police Service, and the implementation team should consult regularly with the Ontario Human Rights Commission in relation to the implementation of this Report's recommendations, insofar as they relate to the Commission's mandate.
103. (Recommendation 151) As a last resort, the civilian members of the implementation team should be made aware of the option to file a complaint under the Human Rights Code or under the Community Safety and Policing Act 2019, when proclaimed, to the Office of the Inspector General if they believe that either the Toronto Police Services Board or the Toronto Police Service are not prepared to make needed changes to address the systemic issues this Report identifies.

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### **2.2.17. Transforming Policing and Community Safety in British Columbia: the "Routley Report" (Special Committee on Reforming the Police Act, 2022)<sup>199</sup>**

The Special Committee on Reforming the Police Act was appointed by the BC Legislature to inquire into policing issues, including oversight, systemic racism, the need for reform of policing legislation to comply with the UN Declaration on the Rights of Indigenous Peoples (UNDRIP),<sup>200</sup> and the role of police in dealing with complex social issues such as addictions and mental illness. The Committee considered all police forces in British Columbia, including the RCMP. The Committee was chaired by Doug Routley, MLA for Nanaimo-North Cowichan, and the report is known as the "Routley Report." The Committee consulted with government officials, police oversight agencies, organizations, and experts. They also conducted a public consultation and a survey of personal and frontline experiences.

The report said the following about systemic racism in British Columbia:

Systemic racism, which consists of organizational culture, policies, procedures, and practices that create and maintain the power of certain racial groups over others or reinforce the disadvantage of certain racial groups, exists in policing in British Columbia. This was evident in the experiences shared with us and reflected in the recommendations we received. Throughout our consultation, we heard about a lack of trust between many

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<sup>199</sup> "Transforming Policing and Community Safety in British Columbia" (the "Routley Report"). Report of the Special Committee on Reforming the Police Act (April 2022), [https://www.leg.bc.ca/content/CommitteeDocuments/42nd-parliament/3rd-session/rpa/SC-RPA-Report\\_42-3\\_2022-04-28.pdf](https://www.leg.bc.ca/content/CommitteeDocuments/42nd-parliament/3rd-session/rpa/SC-RPA-Report_42-3_2022-04-28.pdf).

<sup>200</sup> UN Declaration on the Rights of Indigenous Peoples, adopted by the General Assembly 13 September 2007, <https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html>.

individuals, communities, and the police, particularly Indigenous and racialized communities. To rebuild this trust, a significant shift in police culture is needed.<sup>201</sup>

The Committee also heard concerns about the simultaneous over- and under-policing of Indigenous communities. Efforts to enable Indigenous-led policing were ineffective, and policing in First Nations was funded on a program basis rather than treated as an essential service, as it is off-reserve. The Committee recommended that Indigenous communities have direct input into the policing arrangements that affect them. It noted that the Declaration on the Rights of Indigenous Peoples Act, which establishes the UN Declaration on the Rights of Indigenous Peoples as the framework for reconciliation in British Columbia, requires the informed consent of Indigenous people to legislative or administrative measures that affect them. It recommended the implementation of a new Community Safety and Policing Act, which would highlight anti-racism as a value. It also recommended the collection of race-based data, in consultation with racialized and Indigenous communities, in order to improve anti-racist policies in policing.

In rural communities and small municipalities in BC, the RCMP is responsible for policing. Larger municipalities can choose to use the RCMP or to create their own municipal police service. Municipalities with their own police services have municipal police boards, providing for local governance and accountability; those communities who use RCMP police services—roughly 75% of the population—do not. Governance decisions relating to the RCMP are made in Ottawa. There is also a lack of clarity in the Police Act as to the services to be provided by police, who pays for the service, and other issues. These inconsistencies have resulted in different levels of service in different communities. As well, smaller departments experience small fluctuations in resources more severely than other departments. It is also time-consuming to seek additional resources, and such requests are not always successful.

Another issue identified by the committee is the lack of access to policing data across the province. That in turn has made it difficult for the government to monitor trends in public safety and policing services and make appropriate adjustments to policy.

Although the Ministry of Public Safety and Solicitor General reported that the RCMP made every effort to meet and exceed policing expectations, there were governance challenges with respect to the RCMP's ability to meet policing priorities set by the federal, provincial, and municipal governments at the same time. This affected their ability to respond to the needs and priorities of local communities. Some bodies with which the Committee consulted stated that the RCMP does not align with BC norms and community culture as well as municipal police services do, and others described the contracting system as "unworkable." Numerous submissions suggested the creation of a new provincial police service, although cost and training of this force was identified as an issue.

Although polling showed that the majority of BC residents has a favourable view of police, and it was recognized that policing is an extremely stressful and dangerous job, the Committee's survey suggested that many people do not trust and even fear the police. Lack of trust in the police leads to fewer calls for assistance and makes the job of policing even more difficult. However, many felt that police do not have the time or resources to build community relationships. The Committee also heard concerns about police treatment of sex workers, including Indigenous and immigrant women, as well as concerns about the criminal-justice-centred approach to drug use and addiction.

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<sup>201</sup> "Transforming Policing and Community Safety in BC," p. 6.

Several stakeholders emphasized the need for an approach to policing focused on community safety and well-being. This approach would include considerations of what safety and wellness look like for oppressed and marginalized people. These initiatives would focus on the root of crime, build trust between police and the communities they serve, and operate on a proactive rather than reactive model. The Report noted that concerns had been expressed about the RCMP and community policing:

Several individuals shared views that the RCMP is not appropriate for community policing, citing the history of colonization and discrimination towards Indigenous peoples, or questioning if the RCMP receive appropriate diversity, inclusion, and cultural training.<sup>202</sup>

The Report also noted the issue of transition from an RCMP detachment to a municipal police service. The Police Act does not allow for two services to have jurisdiction. For this reason, in Surrey, where they were transitioning to a municipal service, the Surrey Police Service was integrating with the RCMP, which was remaining the police of jurisdiction. Once the Surrey Police Service has a majority of officers, it will attain jurisdictional authority. While this arrangement was working well, allowing both services to have jurisdiction would allow the new municipal service to gradually take charge of districts within the municipality during a phased handover.

The Report examined the geographic structure of policing, noting that it impedes coordination and leads to both duplication and gaps in service. It referred to the Missing Women report (summarized below in section 3.5), which found that the lack of coordination between police services in the greater Vancouver area seriously affected the investigation into the missing and murdered Indigenous girls and women in the area, and recommended a regional police service to serve the Greater Vancouver Area. The Report noted that while greater regionalization of policing can bring efficiency, it can also lengthen police response times and affect the relationship between police and the local communities.

Each municipality and agency has the authority to create policies and standards for emergency communications, individually, but the RCMP manages this for many smaller communities. The Committee heard recommendations to create a provincial authority to set policies for 911 services and dispatch, which would allow for consistency across the province and ensure best practices in Indigenous, racialized, and other vulnerable communities.

The province has typically called on RCMP detachments rather than non-RCMP municipal police to assist in emergencies. That places an unequal burden on the RCMP, while also raising concerns about the RCMP's capacity to engage with First Nations communities appropriately during emergencies such as flood and wildfire evacuations.

The Report noted the challenges facing rural and remote communities, including low resources and high numbers of officers on sick leave or restricted duties. Officers typically serve short rotations in small communities to prevent burnout, which does not serve either the officers or communities well. Conservation officers provide backup to the RCMP in BC but are not mandated to do so. In Alberta and Saskatchewan, conservation officers in rural areas do have the mandated authority to respond to 911 calls. Residents in remote areas typically have little access to mental health and social work services, which requires police to take calls which would go to those services in more populated areas. That in turn places pressure on the already stretched police

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<sup>202</sup> "Transforming Policing and Community Safety in BC," p. 21.

services. The Committee recommended changes to the funding model for policing costs that consider the reality of rural and remote communities.

The Committee recommended the establishment of a new provincial police service and an end to contracting with the RCMP. Municipalities could choose whether to use the provincial service or use their own force. It emphasized that “transitioning to a provincial police service is not a reflection on the work of individual RCMP officers; rather, it is a reflection of the challenges with governance and accountability with the current federal model.”<sup>203</sup> A provincial service would allow for consistent training, oversight, standards, and policies across the province and would allow for a more modern police force.

The Report described Community Policing Centres in which community members who staff the centre work with police to create programs to prevent crime and address local concerns. Kwanlin Dun in Yukon has a group of safety officers, trained in first aid, substance use, addictions, conflict resolution, and child and family dynamics, who patrol neighbourhoods, unarmed. Other policing models have peace officers or community safety officers who perform duties traditionally assigned to police but which require less training. Those officers can also have special training in mental health and social issues. The Committee commended these kinds of tiered policing programs. It also recommended the amalgamation of police services by region in certain areas of BC to address gaps in communication and administration and improve service delivery.

The Report also noted concerns among stakeholders with the municipal police boards, including a lack of provincial policy frameworks to assist the boards to meet provincial standards; difficulty measuring police performance; a lack of feedback from boards on provincial policy changes; and a lack of consistency across regions due to the fact that provincial policing priorities do not apply to all police services in the province. There were also concerns about the lack of accountability and transparency of police boards and limited opportunity for community engagement with and representation on local police boards. The lack of diversity (including racialized and Indigenous members) and people with lived experience on police boards was another theme of the consultations and submissions. There was also a need for training and guidance for board members on issues such as governance, finances, board responsibilities, and modern policing. The Committee also heard that due to resource constraints, board members are often volunteers who may be taking on a role that is too complex for an unpaid position. Finally, the conflict between police boards and city councils caused by police boards’ ability to approve police budgets without input from council even though councils are the taxation authority, was the subject of significant discussion in the Report. Local communities have limited power to shift or cap police service resources. Police boards can also appeal any attempts by local communities to shift or cap police service resources to the provincial government, which was described by some stakeholders as undemocratic.

The Committee concluded that the oversight framework in place was confusing to navigate. The Independent Investigations Office, which investigates deaths or serious injuries in which RCMP or municipal police are involved, appeared to be working well. However, there were concerns about the Office of the Police Complaint Commissioner (OPCC), which hears complaints related to municipal and provincially-appointed police officers, and the Civilian Review and Complaints Commission (CRCC), which hears complaints related to RCMP officers. These problems included a significant lack of trust in either body by Indigenous and racialized people and other vulnerable groups. The Committee heard that past inquiries and reviews had recommended that Indigenous

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<sup>203</sup> “Transforming Policing and Community Safety in BC,” p. 78.

communities have more of a role in these oversight bodies. There was also overlap and fragmentation between the various agencies. With respect to the CRCC, the Committee noted,

Oversight of RCMP officers was another theme. The Committee heard from the Ministry of Public Safety and Solicitor General that CRCC oversight mechanisms are not as robust as those of the OPCC as the CRCC is dependent on the RCMP detachments to conduct its investigations and lacks the authority to step into the investigative process. The Ministry stated that long-standing concerns with respect to oversight of RCMP officers contributes to a perceived lack of trust and accountability in police oversight at large. The Hon. Wally Oppal further noted that the CRCC does not have the strict time limits for dealing with complaints that are present in the BC Police Act and does not have the authority to make binding decisions and was of the view that the RCMP has been an unwilling participant in BC's complaints process.<sup>204</sup>

The Committee determined that there should be a single, civilian-led, independent agency to provide oversight of all police in BC. All complaints should be received by this agency, which would then determine the appropriate approach, including investigation of criminal allegations, restorative approaches such as facilitated discussions to repair relationships, and triage of performance issues to the police board or union. Its work should be transparent, accessible, and trauma-informed, with navigation supports for complainants and reasonable time limits for complaints to be processed. Officers should be required to report misconduct by their colleagues, including racist and misogynistic conduct, and those who do should be protected from retaliation.

With respect to the staffing of this agency, some stakeholders opposed having investigators with policing experience conducting investigations of police, noting that this practice raises concerns about independence and can deter complainants from reporting. Other individuals who had served as police officers and representatives of policing organizations argued that investigators without a policing background are not qualified to assess police actions and cannot understand real-world judgment calls that officers have to make. Some suggested that having both civilian and police-trained investigators would ensure the integrity of investigations. Similarly, there were differing views on whether the director of the new agency should be a civilian or someone with a policing background.

The Committee also noted the need to ensure the proper funding of this agency. Stakeholders also emphasized the need for more transparency about police misconduct, including data collection and clear communication from the new oversight agency about the reasons for its decisions.

The Report also considered the use of force by police, including the overrepresentation of Indigenous and racialized people and people with mental health symptoms among those who die as a result of the use of force by police. Training and tools had been developed to focus on de-escalation techniques in response to these concerns. The Committee also noted concerns expressed by stakeholders about police use of weapons, including tear gas, and the increasing militarization of the police. Participants noted that military-style uniforms and vehicles can be intimidating and can affect police–community relations.

Stakeholders also called for provincial standards for police-based victim services, noting the difficulty victims experience trying to navigate services and resources following a crime and the unique ability to assist survivors and aid their recovery that police have as the first point of contact

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<sup>204</sup> "Transforming Policing and Community Safety in BC," p. 65.

with the judicial system for most survivors. Community-based victim services are also of particular importance to survivors of gender-based violence, sexual violence, and crimes affecting racialized people. Victim services should be available to the families of victims.

Restorative and alternative justice was another theme of the report. Most referrals to these forms of justice come from police, so there is significant need for police awareness of these options. Reference was made to BC's First Nations Justice Strategy,<sup>205</sup> which takes a "presumption of diversion" approach at all stages of the criminal process. Access to services and support in the community is also essential to the success of restorative justice systems. These programs can generate significant cost-savings but are underfunded.

The Committee heard submissions on the need for increased diversity, as well as developing an organizational culture in police services fostering accountability, inclusion, and belonging. The Report noted the submission of the BC Association of Police Boards, which noted that "if police boards are to recruit and retain a diverse, highly skilled, and ethically minded police service, it must be made clear from both the provincial government and boards that a positive culture is expected and supported, and that policing is valuable and valued work is done on behalf of, and as part of, the communities they serve."<sup>206</sup> Police services had made efforts to increase diversity and train their members on unconscious bias and stereotyping, but those efforts alone can and have not overcome the entrenched problems of systemic racism. Diversity in leadership positions, both in policing and the justice system, is particularly important.

Screening recruits and candidates for promotion was another issue addressed by the Committee. Several individuals and organizations called for improved psychological screening and evaluation to identify bias and authoritarian tendencies.

An expert on police culture, Dr. Angela Workman-Stark, identified resistance to change, a cult of masculinity, and a competitive environment as some of the common traits of police culture. She said that conditioning through police culture is a much stronger cause of negative conduct by officers than inadequate screening or training. She and other experts suggested that good leadership can positively influence police culture. The emphasis on tactics rather than de-escalation and human relations as essential police skills keeps men in positions of authority. The phenomenon of harassment and bullying, particularly of female and minority members, also requires reform to leadership, training, and discipline to create a culture of diversity and acceptance within the police.

The Report noted calls for increased collaboration with mental health service providers in order to ensure effective police response to people in crisis. Suggestions included increased use of databases that allow police officers to access mental health information about individuals and receive immediate assessments to enable appropriate medical responses, programs that pair officers with mental health professionals or specially trained paramedics to respond to mental health calls, Mobile Crisis Response Teams, and allowing civilian response to mental health calls

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<sup>205</sup> See the BC First Nations Justice Council website "The BC First Nations Justice Strategy," <https://bcfnjc.com/landing-page/justice-strategy>. The strategy was developed jointly by the BC First Nations Council, BC First Nation communities, and the government of British Columbia. The Report explains that the strategy "aims to make transformative changes to the justice system and address the lack of culturally appropriate justice services and over-incarceration of Indigenous peoples. The strategy mandates the justice system and its partners undertake work to reform the existing justice system to make it safer, culturally relevant, and more responsive to Indigenous peoples as well as undertake consistent and coordinated action to support the development of First Nations justice systems and institutions consistent with UNDRIP." "Transforming Policing and Community Safety in BC," p. 56.

<sup>206</sup> "Transforming Policing and Community Safety in BC," p. 30.

where safety is not considered an issue. However, the lack of proper funding for these initiatives has meant that police still respond to calls even when others could provide a more appropriate response. Currently, police are the only service that is available 24 hours a day to conduct wellness checks and has the authority to breach doors and take other steps when a person's well-being is at risk. However, civilian-led wellness check programs could reduce the incidence of police use of force during wellness checks. Programs that support people living with addictions and mental health issues, including culturally appropriate services for Indigenous people, can also reduce the need for police calls. Many stakeholders noted that redirecting police funding from wellness and mental health checks could provide more funding for mental health and other social supports; however, it was also pointed out that police funding comes from municipal budgets, whereas health and addictions programs, for example, are paid for by the province. The Committee concluded that police should not be the primary responders to calls where mental health, addictions, or other social issues are the reasons behind the call. A continuum of response to these issues, focused on prevention and community-led initiatives, would be required to enable a civilian-first approach to mental health and addictions calls.

The toll of stress on officers, who experience hundreds of critical incidents over their careers and who themselves have a high incidence of mental health crises, can lead them to make unsafe decisions and have devastating effects on them and their families. However, the Report noted submissions to the effect that many RCMP officers do not make use of the mental health resources that are available to them, due to cultural norms that make them feel weak or vulnerable.

The Committee noted that calls to police relating to domestic violence had increased substantially since 2013, and calls to a Vancouver domestic violence crisis line spiked by 300% during the COVID-19 pandemic. However, survivors of domestic violence frequently state that they would not report to the police. One stakeholder said the police had failed survivors of sexual and intimate partner abuse. Another participant argued that it is inhumane to put survivors through the trauma of investigation, physical examination, and cross-examination when such efforts are often futile. Several organizations noted the lack of standard policies, mandatory training, or oversight for responses and investigations of sexual assault in British Columbia; instead, each police department has their own policies and regulations. One organization, Battered Women's Support Services, recommended a comprehensive review of the policing of intimate partner violence and sexual violence, and reported poor practices by police investigating these issues, including failing to interview neighbours and other potential witnesses. Stakeholders called for more training on gender-based violence and sexual assault and noted that the response of police to the first call affects a survivor's approach to the trauma for the rest of their lives. Unconscious bias may cause officers to imply blame to the victim or sympathy for the perpetrator. Organizations also called for improved community-based services for women, which are underfunded in relation to the prevalence of family and gender-based violence.

The organization that provides training for recruits and police officers differs depending on whether they are employed by a municipal department or the RCMP. There were suggestions to change the training approach to make the training standards in the Police Act less traditional, to provide annual professional development programs similar to other regulated professions, and to create a Centre for Policing Excellence within the Police Academy. There were also suggestions that rather than use the current piecemeal workshops, training should be comprehensive to ensure reinforcement of new practices. There were also suggestions to require university degrees prior to recruitment and a suggestion that degrees focused on policing, similar to social work degrees, be required. Concerns about funding and evaluation of training were also raised.

The Committee concluded that enhanced and standardized training and education were required to shift police culture and build public trust. The effectiveness of this training should be assessed with reference to shifts in culture and behaviour rather than to the number of courses completed. Recruitment assessment should focus on diversity, including diversity of life experience; awareness of bias; humility; honesty; empathy; and sympathy. Performance assessment should also consider social skills and understanding of diversity. The Committee also recommended more regular psychological assessments of police officers, given their exposure to stress and trauma.

Noting that its recommendations would take years to realize with successive governments in place, the Committee recommended an all-party committee to oversee the implementation of the Committee's recommendations. That committee could also review the new Community Safety and Policing Act from time to time and work with government and stakeholders to address other policing issues in BC.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. Implement a new Community Safety and Policing Act to govern the provision of policing and public safety services based on values of decolonization, anti-racism, community, and accountability. This includes:
  - a. Ensuring Indigenous peoples and nations, and municipal governments, are engaged in the drafting of the legislation.
2. Transition to a new BC provincial police service that is governed by the new Community Safety and Policing Act. This includes:
  - a. Establishing a governance model, such as municipal or regional police boards or committees, that is representative of the community and provides opportunities for local input on policing and public safety priorities.
  - b. Ensuring municipal council representation on municipal police boards or committees, while not allowing the mayor to serve as board chair.
  - c. Amalgamating police services on a regional basis where there are opportunities to address fragmentation, ensure equitable access to policing and public safety, and improve efficiency and effectiveness.
  - d. Enabling two police of jurisdiction to facilitate the process of transitioning from one service to another.
3. Ensure all Indigenous communities have direct input into their police service structure and governance, including self-administered services which could provide policing to neighbouring non-Indigenous communities.
4. Create and appropriately fund a continuum of response to mental health, addictions, and other complex social issues with a focus on prevention and community-led responses and ensuring appropriate first response. This includes:
  - a. Increasing coordination and integration across police, health, mental health, and social services.
  - b. Integrating mental health within 911 call options.
5. Ensure equitable access to high quality police and public safety services across BC. This includes:
  - a. Ensuring all policing is responsive to and informed by the community.

- b. Implementing and enforcing provincial standards, policies, and expectations for service with respect to responding to individuals experiencing a mental health crisis, conducting wellness checks, responding to sexual assault, and conducting trauma-informed interviews.
    - c. Adopting a dynamic and flexible approach to policing that provides for different categories of policing and public safety personnel who have clearly defined roles, responsibilities, and functions such as responding to nonviolent incidents and other situations that may not require uniformed police.
    - d. Expanding the use of culturally appropriate restorative justice programs throughout BC, including increased funding for these programs and education for police officers.
6. Create a fair and equitable shared funding model for municipalities. This includes:
  - a. Consideration of local needs, health and social supports, and the geography of a service delivery area.
  - b. Exploring options to phase in or incrementally increase the municipal share of policing costs.
7. Enhance and standardize initial and ongoing police education and training to reflect key values and competencies in order to shift police culture. This includes:
  - a. Ensuring police and public safety services are representative of the diversity of the communities served (including diversity of race, ethnicity, gender, and sexuality) via recruitment.
  - b. Implementing screening and performance evaluation for existing officers and new recruits that reflect desired values and principles, including humility, honesty, empathy, and lack of bias and prejudice, to ensure that these individuals are best suited for their current position or for advancement and are a good fit for the community.
  - c. Conducting regular mandatory psychological assessments for all police officers in BC.
  - d. Enhancing and standardizing training required for police recruits and implementing mandatory and meaningful ongoing education with respect to anti-racism, cultural competency, and trauma-informed practices.
  - e. Requiring police officers to complete training and education that are based on the historical, cultural, and socio-economic context of the communities in which they will be serving and are developed and delivered in consultation with the communities.
  - f. Developing benchmarks to measure the efficacy of police training and education with respect to a shift in police culture and conduct.
8. Require police services to collect and publicly report disaggregated race-based and other demographic data and conduct comprehensive reviews of and amend policies and procedures to address systemic racism in policing.
9. Establish a single, independent, civilian-led oversight agency responsible for overseeing conduct, complaints, investigations, and disciplinary matters for all police and public safety personnel with powers or authority under the new Community Safety and Policing Act. This includes:
  - a. Prioritizing the creation of stand-alone legislation for police oversight.
  - b. Ensuring the oversight agency is reflective of the diverse population and cultures of BC.
  - c. Providing navigation and triaging services to assist complainants throughout the complaints process.

- d. Implementing a multi-stream approach to processing complaints, expediting minor performance and procedural matters, and offering multiple resolution pathways such as direct conversations, mediation, or restorative justice.
- e. Revising the definition of misconduct to include demeaning and discriminatory conduct, language, jokes, statements, gestures, and related behaviours.
- f. Establishing a duty to cooperate with investigations and a duty to report misconduct for all police and public safety personnel with protections for reporting.

The Committee recommends that the Legislative Assembly:

- 10. Immediately appoint an all-party parliamentary committee to undertake a broad review of the Mental Health Act with a view to modernizing the Act and ensuring it aligns with the recommendations in this report.
- 11. Establish an all-party select standing committee on policing and community safety to:
  - a. Oversee the implementation of changes recommended in this report.
  - b. Conduct regular reviews of the new Community Safety and Policing Act.
  - c. Examine standards, policies, and programs related to the provision of policing and public safety in BC and report annually on this work.
  - d. Work with key partners to address colonial structures and systemic racism in policing.
  - e. Receive and review annual updates from the Ministry of Public Safety and Solicitor General regarding emergent issues in policing and community safety and the effectiveness of police services in BC.

### 3.COMMUNICATIONS AMONG AND WITHIN LAW ENFORCEMENT AGENCIES

The Order in Council directs the Mass Casualty Commission to examine “communications between and within the RCMP, municipal police forces, the Canada Border Services Agency, the Criminal Intelligence Service Nova Scotia, the Canadian Firearms Program and the Alert Ready Program”((b)(vi)).

#### 3.1. Kaufman Commission on Proceedings Involving Guy Paul Morin (Ontario, 1998)<sup>207</sup>

Guy Paul Morin was wrongly convicted of first-degree murder of nine-year-old Christine Jessop, his next-door neighbour, who was abducted, sexually assaulted, and killed in 1984. Mr. Morin was acquitted after his first trial in 1986; the Crown successfully appealed, and in 1992 after a retrial, Mr. Morin was convicted. Mr. Morin appealed again, and in 1995, ten years after he was arrested, he was acquitted on the basis of DNA evidence. In 1996, the Ontario government appointed the Honourable Fred Kaufman, QC, to conduct a public inquiry into the investigation, the forensic evidence, and the criminal proceedings. Justice Kaufman’s report was released in March 1998. Justice Kaufman found serious problems with the reliability and use of forensic hair comparison and fibre comparison evidence at Mr. Morin’s trials. He also concluded that two in-custody informants who testified that they heard Mr. Morin confess to the crime had lied. Tunnel vision had strongly affected the investigation and prosecution of Mr. Morin, and some officers changed their evidence as the proceedings progressed in ways that assisted the prosecution. As well, some information that could have assisted Mr. Morin’s defence was not disclosed.

Justice Kaufman also made the following findings regarding the conduct of the York Regional Police, who initially investigated Christine Jessop’s disappearance:

1. York Regional Police did not have an adequate system to ensure that tips and investigative steps were followed to conclusion. There was no system to prioritize the steps in the investigation or to ensure that investigating officers were aware of what other officers had done or learned. This resulted in leads and tips falling through the cracks.<sup>208</sup>
2. Police failed to document important information. For example, witness statements that could have assisted Mr. Morin in establishing his alibi were not recorded and could not be confirmed when they came to light years later. As well, the system used by York Regional Police to index and file investigation reports, which Justice Kaufman described as “archaic,” did not allow officers to search by subject area. This prevented searches of all apparent sightings of Christine Jessop, for example.<sup>209</sup>
3. Before Christine Jessop’s body was found, York Regional Police were not mindful of the possibility that a serious crime had taken place, instead treating it as a missing person’s case. This led to an informal approach to collecting and protecting evidence, including a failure to properly canvass the homes in the neighbourhood.<sup>210</sup> They took this informal approach in spite

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<sup>207</sup> “The Commission on Proceedings Involving Guy Paul Morin: Report” (the “Kaufman Report”) Government of Ontario (March 1998).

<sup>208</sup> “Kaufman Report,” p. 654.

<sup>209</sup> “Kaufman Report,” p. 655.

<sup>210</sup> In 2020, Toronto Police Service, which had taken over the investigation from Durham Regional Police, announced that DNA testing had identified a friend of the Jessop family, Calvin Hooper, as Christine Jessop’s likely killer. Media stories stated that police never spoke to Hooper about Christine Jessop’s disappearance, although police did speak to his wife. See, for example, J. Grimaldi. (2021). “Just Pure Evil”: The Downfall of Christine Jessop’s Killer, Calvin

of evidence of damage to Christine Jessop's bicycle, her age, the lack of any history of family turmoil, and the lack of any trace of her in her small community.

4. A 1997 audit of the York Regional Police Service had identified significant deficiencies in officer training. The only area where training was satisfactory was an area where there were mandated provincial standards; however, policing in Ontario was mostly governed by non-mandatory guidelines. Despite the audit results, few improvements had been made to training of officers in York. Justice Kaufman said:

The lessons which may be learned from this Inquiry by police officers will mean little if the rank-and-file police officers are not taught them. The practices and procedures recommended by me in this Report will mean little if officers are not trained in their use. The dangers identified in the conduct of police investigations will have been identified for nothing if officers remain unaware of them.<sup>211</sup>

Traditional protocol in Ontario required that the police force in the area where a body is found take jurisdiction over the homicide investigation, regardless of where the abduction leading to the homicide took place. For this reason, the Durham Regional Police Service took over the investigation, although York Regional Police had been investigating Christine Jessop's disappearance for three months by the time her body was found in Durham Region. Justice Kaufman considered whether that protocol should be changed. Durham officers testified that they found it difficult to review the York investigation reports following the transfer and never did receive the entire file. However, Justice Kaufman found that the relationship between the two forces was good.

Justice Kaufman also identified numerous problems with the conduct and evidence of the Durham Regional Police, including improper shaping of witness testimony, an improper focus on innocuous comments and behaviour by Mr. Morin, overreliance on polygraph results, promotion of investigators who developed the "best suspect," and testimony by officers at the second trial that Justice Kaufman concluded may have been deliberately concocted in order to buttress the Crown's case. He concluded:

An investigation can be perfectly structured but flounder due to tunnel vision or "noble cause corruption" or loss of objectivity or bad judgment. Older techniques and thought processes are, at times, deeply ingrained and difficult to change. Police culture is not easy to modify. The failings which I identified were systemic and were not confined to several officers only. The challenge for Durham will be to enhance policing through an introspective examination of the culture. I am convinced that such an examination has commenced.<sup>212</sup>

Justice Kaufman heard evidence about the efforts of the Durham Regional Police to improve its investigations in the years following Mr. Morin's arrest. These efforts included the establishment of the Durham Police Learning Centre on the campus of Durham College, which led to far more continuing education for Durham members than had previously been feasible, and mandatory officer education on investigation techniques and ethics in policing. Durham had also adopted a case management model before the provincial model recommended in the Bernardo Review (summarized in section 3.3. below) was launched and had adopted approaches to improve multijurisdictional investigations.

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Hoover." Toronto.com News (25 January 2021), <https://www.toronto.com/news-story/10273374--just-pure-evil-the-downfall-of-christine-jessop-s-killer-calvin-hoover/>.

<sup>211</sup> "Kaufman Report," p. 676.

<sup>212</sup> "Kaufman Report," p. 41.

## **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. Skills, Training, and Resources:
  - a. Rank-and-file officers need be educated and trained on a continuing basis on a wide range of investigative skills. Their educators need themselves be fully trained in these skills and in their communication to others. Financial resources need be available, secure from erosion for operational purposes, to ensure that training for all Ontario police forces is state-of-the-art.
  - b. Attention should be given by the Government of Ontario, on a priority basis, to the specific concerns identified by the York Regional Police Association and the audit of the York Regional Police force. The Government of Ontario should publicly announce the measures being taken to address the concerns raised.
2. Education respecting wrongful convictions:
  - a. The Ministry of the Attorney General, in consultation with the Ontario Crown Attorneys' Association, should develop an educational program for prosecutors which specifically addresses the known or suspected causes of wrongful convictions and how prosecutors may contribute to their prevention. This program should draw upon the lessons learned at this Inquiry. Adequate financial resources should be committed to ensure the program's success and its availability for all Ontario prosecutors.
  - b. An educational program should be developed for police officers which specifically addresses the known or suspected causes of wrongful convictions and how police officers may contribute to their prevention. The Ministry of the Solicitor General should take a leading role in promoting this programming. This program should draw upon the lessons learned at this Inquiry. Its design should be effected through the cooperative assistance of prosecutors and defence counsel. Adequate financial resources should be committed to ensure the program's success and its availability for all police investigators, both new and established.
  - c. The Criminal Lawyers' Association should develop an educational program for criminal defence counsel which specifically addresses the known or suspected causes of wrongful convictions and how defence counsel may contribute to their prevention. This program should draw upon the lessons learned at this Inquiry.
  - d. The Centre of Forensic Sciences should develop an educational program for its staff, including all scientists and technicians, which specifically addresses the role of science in miscarriages of justice, past and potential. This program should draw upon the lessons learned at this Inquiry. Its design should be effected through the cooperative assistance of prosecutors and defence counsel. Adequate financial resources should be committed to ensure the program's success and its availability for all Centre staff, both new and established.
  - e. Ontario law schools and the Law Society of Upper Canada Bar Admission Course, should consider, as a component of education relating to criminal law or procedure, programing which specifically addresses the known or suspected causes of wrongful convictions and how they may be prevented.
  - f. The judiciary should consider whether an educational program should be developed which specifically addresses the known or suspected causes of wrongful convictions and how the judiciary may contribute to their prevention.

3. Education respecting tunnel vision: One component of educational programming for police and Crown counsel should be the identification and avoidance of tunnel vision. In this context, tunnel vision means the single-minded and overly narrow focus on a particular investigative or prosecutorial theory so as to unreasonably colour the evaluation of information received and one's conduct in response to that information.
4. Police culture and management style: Police forces across the province must endeavour to foster within their ranks a culture of policing which values honest and fair investigation of crime and protection of the rights of all suspects and accused. Management must recognize that it is their responsibility to foster this culture. This must involve, in the least, ethical training for all police officers.
5. Case management system:
  - a. The standardized case management system recommended in the Campbell Report [the Bernardo Investigation Review, summarized in section 3.3. below] should be implemented as soon as possible.
  - b. Adequate resources should be made available to train sufficient senior police investigators to ensure that the case management system is used in all major crime investigations across Ontario.
  - c. There should be periodic review and updating of the case management system, incorporating best practices from around the world.
  - d. Audits should be conducted by "peer review" teams to ensure that the case management system is being applied properly and consistently.
6. Minimum standards for police:
  - a. The Ministry of the Solicitor General should consider setting minimum provincial standards respecting the initial and ongoing training of police officers on a full range of subjects, relevant to the issues identified at this Inquiry.
  - b. The Ministry of the Solicitor General should consider setting minimum provincial standards for the conduct of criminal investigations, relevant to the issues identified at this Inquiry.
  - c. The content of policing manuals which guide Ontario police officers in the performance of their duties, such as the Canadian Police College Manual, should be revisited to reflect the lessons learned at this Inquiry.
7. Structure of police investigation: Investigating officers should not attain an elevated standing in an investigation through acquiring or pursuing the "best" suspect or lead. This promotes competition between investigative teams for the best lead, results in tunnel vision and isolates teams of officers from each other.
8. Review of completed investigations: There should be an institutionalized requirement for review of all major crime investigations once completed.
9. Committee to Oversee Implementation of Recommendations: The Government of Ontario should constitute a committee to oversee the implementation of recommendations contained in this Report which are accepted. Such a committee should issue periodic reports, which are publicly accessible.

### 3.2. Inquest into the Death of Jonathan Yeo: Verdict of the Jury (Office of the Chief Coroner of Ontario, 1992)<sup>213</sup>

Jonathan Yeo had a long history of violence and was known to police and mental health service providers. In 1991, Yeo was charged with sexual assault, forcible confinement, and uttering threats after threatening a woman with a knife and a gun. He was released on bail with no weapons restrictions. He tried to leave the country; a US customs official in Niagara Falls refused him entry and reported him to the Niagara Regional Police and Hamilton-Wentworth Police. He had his rifle and live ammunition in his car, as well as a suicide note. However, police declined to arrest Yeo. Canadian border officials felt they had no legal right to seize his weapon, and they permitted him to return into Canada. An hour later, Yeo abducted and sexually assaulted a young woman, Nina de Villiers, and killed her using the same rifle he had used in the prior assault. He then went to New Brunswick, where he killed Karen Marquis. He shot himself in Hamilton while being pursued by police for these murders. A representative of the Attorney General said publicly that the Crown Attorney did everything possible to make sure Yeo was prohibited from possessing a weapon when he was granted bail. This statement has been publicly challenged.<sup>214</sup>

There was no commission of inquiry into the incidents, but a coroner's inquest into Mr. Yeo's death in Ontario heard evidence over 46 days and made 137 recommendations for the police services involved, the provincial Attorney General's office, and mental health service providers.<sup>215</sup> There were no written findings by the jury.

#### Recommendations Relevant to the Mandate of the Mass Casualty Commission

1. (Recommendation 19) The Chief of Police of the Hamilton-Wentworth Regional Police Service or his designate shall issue a special directive to all investigative personnel relating to offences which may involve the use of a firearm. [...]
2. (Recommendation 20) The directive shall list all powers of an investigator to search for and seize firearms. It shall include powers of search incidental to an arrest, and with or without a search warrant, pursuant to the provisions of the Criminal Code.
3. (Recommendation 21) The directive shall also provide that in every investigation which may involve the use of a firearm, the investigator shall:
  - a. Consider all of his powers of search and seizure and document the powers that were exercised to search for firearms and other reasons why other powers were not pursued. He shall also document the results of any search conducted;
  - b. Make such inquiries of the accused, family members, or other associates as may reasonably be practicable to ascertain whether weapons are available to the accused;
  - c. Make appropriate inquiries to ascertain whether or not the accused is in possession of a Firearms Acquisition Certificate [...]

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<sup>213</sup> "Inquest into the Death of Jonathan Yeo: Verdict of the Jury." Office of the Chief Coroner of Ontario and Ministry of the Solicitor General (August 1992), [https://ia600100.us.archive.org/26/items/mag\\_00007542/mag\\_00007542.pdf](https://ia600100.us.archive.org/26/items/mag_00007542/mag_00007542.pdf).

<sup>214</sup> Because the jury made very limited factual findings, this information was taken from the website of CAVEAT (Canadians Against Violence Everywhere Advocating for its Termination). CAVEAT was created by Ms. de Villiers' mother, Priscilla de Villiers, to ensure that the jury's recommendations were implemented. Priscilla de Villiers is on the Advisory Committee on Victim Issues for the Policy Centre on Victim Issues at the Department of Justice, Canada. See [https://www.caveat.org/publications/sw/cav\\_1992\\_sep.html](https://www.caveat.org/publications/sw/cav_1992_sep.html) and <https://www.caveat.org/history/>.

<sup>215</sup> "This Day in History." *Hamilton Spectator* (13 April 2012), <https://www.thespec.com/news/hamilton-region/2012/04/13/this-day-in-history.html>.

### 3. COMMUNICATIONS AMONG AND WITHIN LAW ENFORCEMENT AGENCIES

4. (Recommendation 24) The Solicitor General or his designate shall ensure that police services throughout the Province issue a directive in similar terms;
5. (Recommendation 32) Any police service in whose jurisdiction the accused is to reside or report [following release on bail] shall:
  - a. Establish a procedure for the receipt and storage of the information received from the police force which charged the accused and a procedure for using such information to protect the public;
  - b. Promptly report to the investigator, where practicable, and otherwise to the police service which charged the accused of any breach or “about to breach” situation which comes to its attention.
6. (Recommendation 33) The Solicitor General or his designate shall direct that all police services throughout the Province adopt the procedures set out in this section.
7. (Recommendation 34) Where a large police service has several divisions at different locations, the Solicitor General or his designate shall direct such a police service that these procedures apply with such modifications as may be required, i.e. where one division charges an accused who is to report or reside within another division of the same police service.
8. (Recommendation 37) Police must get full training concerning Canadian Police Information Centre [CPIC].
9. (Recommendation 38) The information on CPIC must be standard across Canada.
10. (Recommendation 40) The evidence at this Inquest has indicated that police services in the Province are not always able to obtain and use information in the hands of other police services. The evidence has indicated that such information, in particular prior police occurrences, may be essential to proper police preparation of bail briefs. Accordingly, the Solicitor General or his designate shall immediately consider the implementation throughout the Province of a uniform computer storage system of police information storage to ensure full and ready access to police records by all police services in the province.
11. (Recommendation 41) Until such time as the above uniform computer system is in place, the Solicitor General or his designate, shall endeavour to implement a system enabling a police service in one jurisdiction to ascertain on a computer search that prior occurrence reports in respect of a named individual exist in other police services and to ensure ready access to such prior occurrence reports.
12. (Recommendation 42) The evidence at this inquest indicated that the seriousness of an ongoing police investigation and all relevant police information is [sic] not in all instances adequately disseminated in police broadcasts to service members and to other police agencies. Accordingly, the Chief of Police of the Hamilton-Wentworth Regional Police Service or his designate shall direct that all officers with responsibilities for drafting all-cars bulletins, zone and provincial alerts receive immediate re-training as to the criteria required for each type of alert so that serious crimes will be broadcast on a priority basis.
13. (Recommendation 43) The Chief of Police of the Hamilton-Wentworth Regional Police Service or his designate shall further ensure that all officers with responsibilities for drafting all-cars bulletins, zone and provincial alerts receive immediate re-training as to the appropriate content of zone and provincial alerts in serious criminal investigations. This shall include re-training on matters such as:
  - a. Full description of the suspect;
  - b. Photograph of the suspect;
  - c. Suspect may be armed and dangerous;

- d. Full description of any motor vehicle associated with the suspect;
  - e. Suspect may be suicidal;
  - f. Criminal charges have been laid or are soon to be laid against the suspect;
  - g. The suspect is at large on a recognizance and is in breach of a condition of the recognizance;
  - h. The need to update broadcasts from time to time to ensure that accurate and up-to-date information is being disseminated.
14. (Recommendation 86) The Attorney General or his designate shall ensure that, where victims of violent crime consult with Crown Attorneys or Assistant Crown Attorneys and indicate a reluctance or refusal to have cases prosecuted in Court, the Crown Attorney or Assistant Crown Attorney shall keep complete and detailed notes of such meetings. He shall further ensure that any decision not to proceed with a charge or to withdraw an already existing charge shall be made only after the matter is fully canvassed with input from the investigator assigned to the case and the victim. Any such decision shall be made only after a full review of all available evidence. The reasons for any decision not to proceed shall be recorded and signed by the Crown Attorney or a Senior Assistant Crown Attorney.
15. (Recommendation 87) Regional Director of Crown Attorneys for Central South Region shall discuss with the Attorney General or his designate the matter of communication by the Communications Branch of the Ministry of the Attorney General of inaccurate and misleading information concerning serious offences in the community. The Regional Director shall inform the Attorney General or his designate of the misleading and inaccurate information that was communicated in the Yeo case and the impact of this upon the victims of Mr. Yeo's crimes. The Regional Director shall consult with those persons within the Ministry of the Attorney General responsible for communication of information to the public in cases of this nature so as to ensure that no information is communicated by the Ministry without reasonable steps being taken to ensure its accuracy. In addition, the Regional Director shall, in the course of these discussions, consider whether or not as a matter of policy the victim and/or family should be consulted prior to the release of information to the public.
16. (Recommendation 130) The Solicitor General shall study "The Implementation of an Ontario Central Registry for Violence Sexual Assault Occurrences." The purposes of this Registry shall be to alert law enforcement agencies of previous occurrences of a violent sexual nature relating to person(s) of his/her ongoing investigation and the possibility that the investigated person(s) by their actions may be a serial violent sexual offender, dangerous to the community at large. Reporting such occurrence(s) to the Central Registry must be mandatory. The alleged use of any weapon(s) referable to violent assault or sexual assault occurrence(s) as information about an alleged perpetrator must be of paramount importance to investigators and prosecutors for the protection of the public and the complainant. All information in the Central Registry shall be "confidential," to be shared by all the law enforcement agencies in Ontario.

### 3.3. Bernardo Investigation Review ("Campbell Report") (Ontario, 1996)<sup>216</sup>

Paul Bernardo committed at least fifteen rapes in Scarborough and Mississauga over three years starting in 1987. He continued attacking and stalking women after moving to St. Catharines,

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<sup>216</sup> "Report of Mr. Justice Archie Campbell." Bernardo Investigation Review. Ontario, 1996, <https://www.scribd.com/document/94231897/Paul-Bernardo-investigation-report-June-1996>

Ontario. With his wife, Karla Homolka, he abducted, sexually assaulted, tortured, and murdered two teenage girls. They also sexually assaulted and caused the death of Ms. Homolka's sister. Mr. Bernardo was not caught until DNA testing confirmed he was the Scarborough Rapist, and Ms. Homolka told investigators about his role in the murders.

Following Mr. Bernardo's conviction, the Ontario government asked Justice Campbell to review the investigation of the rapes and murders. He made the following findings:

1. The Metropolitan Toronto police investigators assigned to the Scarborough Rapist investigation took considerable steps to identify and apprehend the perpetrator but did not have enough resources and did not have a case management system. Tips and information came in but were never followed up.
2. In 1988, a police officer from another Toronto district reported to the Scarborough Rapist investigators that a friend had told him about a man, Paul Bernardo, whom she had been seeing. The woman described Mr. Bernardo to the officer as a sexual sadist. He had assaulted her with a knife, commented "why do I keep doing this," and fit the Scarborough Rapist's description. That report was never followed up. No one from the police spoke to the officer or to his friend until Mr. Bernardo was arrested five years later.
3. In December 1990, Mr. Bernardo and Ms. Homolka drugged and sexually assaulted Ms. Homolka's teen sister, Tammy. She aspirated on her vomit and died. Justice Campbell found that police wrongly accepted Mr. Bernardo and Ms. Homolka's explanations for Tammy's death and failed to properly investigate, despite clear red flags.
4. In June 1990, a bank teller reported that her customer, Paul Bernardo, was a dead ringer for the composite photo of the perpetrator that had been posted in the city. She also said he had changed his appearance since those posters had gone up. That tip put Mr. Bernardo in the "A" list of suspects but was similar to many other tips about other potential perpetrators and was not followed up.
5. A few months later, after the Scarborough Rapes stopped, another tip came in from a woman who knew Mr. Bernardo and believed that he resembled the composite drawing of the perpetrator. This woman had heard that Mr. Bernardo would wait until a woman was drunk and then take advantage of her. Investigators did nothing in response. After the woman called again in late 1990, investigators interviewed Mr. Bernardo. They did not consider him a serious suspect. Mr. Bernardo provided blood and saliva samples, which police sent for serology and DNA testing.
6. Mr. Bernardo moved to St. Catharines, Ontario and in 1991 raped another woman within a mile of his house there. This attack was strikingly similar to the Scarborough attacks. The responsible agency, the Niagara Police, sent a CPIC "zone alert" to surrounding police forces, including Metropolitan Toronto. This alert described the attack and asked any department with similar incidents to contact the Niagara investigators. However, the alert did not appear to have come to the attention of the investigators working on the Scarborough rapes.
7. Two months later, in June 1991, Mr. Bernardo and Ms. Homolka abducted, raped, tortured, and killed Leslie Mahaffy. They abducted her from outside her home in Burlington, Ontario, and her body was found encased in cement in Niagara Region. A joint task force, the Green Ribbon Task Force, was created between the Niagara Region and Halton Region police forces. The two forces worked well together, and there were no problems with interjurisdictional policing during their investigation.
8. In July 1991, Mr. Bernardo followed a young woman around St. Catharines on two separate nights. The woman recorded his license plate number on the second occasion and reported

it to a Niagara police officer on street patrol. The officer checked the plate and found that the car belonged to Mr. Bernardo. He did not file a written report or otherwise follow up. The officer said later that he got distracted by another incident and forgot about the report; he also did not think that what Mr. Bernardo was reported to have done was criminal.

9. In March 1992, two young women who were sisters reported being stalked by a man in a gold sports car. They could not clearly make out the license plate but had the correct first three numbers. The police recorded the report but could not tie the reported license plate number to the make of car the women had noted. Three weeks later, on what was likely the last night of Kristen French's life, one of the sisters saw the car again, followed it until she lost sight of it, and made another note of the license plate and specific make and model of the car. This time she was correct except for one digit of the license plate. She reported it to police and made reference to the original report. The officer who took the report did not make any record of the report or cross-reference it to the original report by the sisters. Justice Campbell concluded that the officer did not take the report seriously, and the report went into a "black hole." At the time, he noted, there had been only limited police and public awareness that stalking is a serious safety issue and can be terrifying in its own right and can also be the hallmark of a serial predator. He noted recent changes to the Criminal Code and recent training and protocols for police which were intended to change police responses to stalking.
10. Mr. Bernardo and Ms. Homolka abducted, raped, tortured, and killed Kristen French in April 1992. In May of 1992, the same acquaintance of Mr. Bernardo's who had reported suspicions about him in 1990 told the Green Ribbon Task Force that Mr. Bernardo might be responsible for the Mahaffy and French murders. An officer interviewed Mr. Bernardo and was aware he had been questioned about the Scarborough Rapes. Witnesses to the French abduction reported seeing a Camaro, which did not match Mr. Bernardo's car,<sup>217</sup> and the officer did not believe it likely that Mr. Bernardo would have abducted and murdered a woman within a week of being married, nor would he have willingly given hair and blood samples if he were guilty. The officer spoke to a Toronto investigator and learned they were waiting for DNA results from Mr. Bernardo and other suspects in the Scarborough rapes; he did not learn that there were only five suspects, including Mr. Bernardo, whose serology results matched the Scarborough Rapist. The officer classified Mr. Bernardo as an unlikely suspect. After the interview, Mr. Bernardo and Ms. Homolka hid the videotapes they had made of the murders and the knife they used to kill Lesley Mahaffy in the insulation in the rafters of their garage. Mr. Bernardo said he later moved the videos to a closet in the house.
11. Throughout their relationship, Mr. Bernardo had abused and dominated Ms. Homolka. The abuse became increasingly terrifying. She tried to leave him in June of 1992, but he threatened to expose her role in the murders. During the following months, she described the abuse as, in Justice Galligan's words, "nothing short of a horror story."<sup>218</sup> After a savage beating and at the insistence of her co-workers and family, Ms. Homolka finally left Mr. Bernardo in January of 1993. Before she left, she searched the house for the videotapes but could not find them. Mr. Bernardo later said that after Ms. Homolka left, he moved the videos to a space above a pot light in a bathroom. Mr. Bernardo was charged with assaulting Ms. Homolka; however, there was no indication in Justice Campbell's report that this assault

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<sup>217</sup> As it turned out, the suspicious Camaro that witnesses noticed the day of Kristen French's abduction in the same neighbourhood was driven by a man, not Mr. Bernardo, who was stalking someone else.

<sup>218</sup> The relationship between Ms. Homolka and Mr. Bernardo, and Ms. Homolka's role in the investigation, are detailed in "Report to the Attorney General of Ontario on Certain Matters Relating to Karla Homolka" by the Honourable Patrick T. Galligan, QC (1996). See p. 41.

charge caused investigators to consider him a more serious suspect in the Scarborough rapes or the Green Ribbon murders.

12. On February 1, 1993, Metropolitan Toronto police received the initial DNA test results showing that Mr. Bernardo was likely the Scarborough Rapist. The DNA testing process had not started until fifteen months after Mr. Bernardo's samples were sent, due to miscommunication between the lab and the investigators. The investigators did not follow up with the forensics lab to discover the misunderstanding. Staff shortages in the DNA lab led to a further ten-month delay before the testing was complete in February 1993.
13. Metropolitan Police began surveillance of Mr. Bernardo in St. Catharines but did not inform the Green Ribbon Task Force of this or of the DNA test results for several days. This led to an erosion of trust between the two forces and was ascribed by some Toronto police officers to a desire among some officers in Toronto to "call the shots."
14. Investigators then spoke to Ms. Homolka, who told them about the abuse she had suffered. She later disclosed her involvement in the murders and eventually pleaded guilty to manslaughter in exchange for her testimony against Mr. Bernardo.
15. Mr. Bernardo was arrested on February 17, 1993. He was interviewed jointly by an officer from Toronto and from the Green Ribbon Task Force; however, there were serious problems with cooperation between the two teams and management of the pre-interview process and the interview itself. As a result, the interview was "disastrous." Justice Campbell concluded:

If there was ever an abject example of how things can go wrong when police forces do not co-operate, no one is in charge, and no one accountable, this [interview] is that example. And again, if there was ever an abject example of why it is necessary to develop a co-operative approach among police forces and a system to ensure such co-operation and accountability under a unified leadership structure, this is that example.<sup>219</sup>

Mr. Bernardo was eventually convicted of first-degree murder.

At the time of the Scarborough Rapes investigation, the system police were using was paper-based. There was no computer system in place that would associate a person's name with previous tips regarding the same person or that would flag that a tip had not been investigated. There was also no mechanism to ensure follow-up with forensic testing or to have senior officers oversee the progress of serious cases, even though officers could see from the progression in severity of attacks that the perpetrator was likely to begin killing his victims. Nor was there a mechanism to track similar attacks in different communities. Justice Campbell stated:

[T]here was not then, and there is not now, any organized system that transcends police boundaries and protects the members of other communities against the serial rapist who moves away from his starting place to prey in new locales. When Bernardo stopped raping in Toronto and started raping and killing in St. Catharines, he might as well have moved to another country.<sup>220</sup>

One wonders how many times Bernardo had to be reported to the police before all the police information about him was put together in one place. It was only after his arrest that all the information about him, readily available in the hands of both police forces, was put

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<sup>219</sup> "Bernardo Investigation Report," p. 193.

<sup>220</sup> "Bernardo Investigation Report," p. 34.

together. An effective system puts this information together during the investigation, not after the arrest.<sup>221</sup>

Justice Campbell noted that the strategy needed to combat mobile serial predators must include the following elements:

- Attitude change to recognize that the capture of a serial predator involves a wider public interest than the local concerns of any individual police force and requires a wider law enforcement response than from any one police force.
- A system that will recognize links between crimes early enough to pool the information and converge the separate investigations onto the same target.
- An organizational structure that combines unified leadership across police jurisdictions with organized case management procedures and inter-disciplinary support from forensic scientists and other agencies, centrally supported and based on cooperation between local police forces.
- Computer and information systems common across agencies that will ensure that important information is consolidated and shared.
- Training. Justice Campbell noted that “training is the first thing to cut when budgets shrink” and that good training programs on sexual assault, homicide investigations, and case management are under-used because individual forces cannot afford to have their officers removed from the front line to attend them.

Justice Campbell also noted that several Ontario coroner’s inquests had made recommendations around information-sharing, including the inquest regarding Jonathan Yeo (summarized above in section 3.2.).

Although there had been some discussions in Ontario about changes to the structure of policing in the province, Justice Campbell did not take a position. He stated:

Whether the structure of policing organizations changes or remains the same, these recommendations stand on their own. The principle of a unified investigative strategy driven by co-operation among police forces and forensic agencies will work whether or not our policing structures change or remain the same.<sup>222</sup>

Justice Campbell also addressed the experience of the victims and the need for improvements in police interactions with sexual assault victims. Some victims reported that frontline officers made cruel and insensitive comments;<sup>223</sup> some reported concerns about never knowing who was in charge of their case and having frequent changes in assigned officers. Many reported positive experiences with victim support services.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 1) A major case management system is required for major and inter-jurisdictional serial predator investigations, based on:
  - a. Co-operation rather than rivalry;

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<sup>221</sup> “Bernardo Investigation Report,” p. 161.

<sup>222</sup> “Bernardo Investigation Report,” p. 317.

<sup>223</sup> “Bernardo Investigation Report,” p. 227.

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- b. specialized training for senior officers in charge, senior investigators, and interdisciplinary support teams;
  - c. early recognition of linked offences;
  - d. co-ordination of interdisciplinary and forensic resources;
  - e. simple mechanisms to ensure unified management, accountability, and co-ordination among police forces and law enforcement agencies.
2. (Recommendation 2) A commitment for change is required from the police and law enforcement communities, the Ontario government, and from the community at large.
3. (Recommendation 3) A major case management system for the investigation of serial predators is required to ensure:
  - a. unified direction under one single person in overall charge of and accountable for related investigations;
  - b. supervision of timelines and systematic follow-up of crucial investigative steps such as forensic testing;
  - c. a standard computerized case management system for the recording, organization, management, analysis, and follow-up of tips and investigative leads;
  - d. the consistent, organized classification and elimination of suspects;
  - e. the systematic use of relevant information from other forces such as CPIC zone alerts;
  - f. co-operative provincial oversight and intervention when a serial predator investigation is not pursued vigorously when it becomes a low priority for a local police force.
4. (Recommendation 6) A system is required to better co-ordinate the work of forensic scientists and police investigators.
5. (Recommendation 7) Continuation and support are required for the work of the Chief Coroner's office in developing, for unexplained or suspicious deaths, an interdisciplinary approach to integrate the work of the police, coroners, forensic scientists, and forensic pathologists.
6. (Recommendation 8) A case management system is required to ensure that investigations of sexual predators widen their scope once local leads are exhausted.
7. (Recommendation 9) Mandatory ViCLAS reporting is required to ensure early recognition of links between sexual predator attacks.
8. (Recommendation 10) Increasing awareness and training are required to ensure that stalking is recognized as a serious problem and a potential hallmark of the serial predator and that reported incidents are responded to and documented in accordance with approved procedures.
9. (Recommendation 12) A standard computerized case management information system is required for major sexual assault and homicide investigations that have the potential to involve inter-jurisdictional investigations.
10. (Recommendation 13) A major case management system is required to ensure:
  - a. standardization of interview and statement techniques and consistent criteria for suspect classification and elimination;
  - b. better communication between police forces about common suspects;
  - c. strategic analysis of the benefits of major initiatives and the capacity of the investigation to use the resulting information effectively;
  - d. a high degree of mutual understanding and agreement between police investigators and forensic pathologists on the steps to be taken at a body site and during a postmortem investigation;

- e. effective media relations policies directed in major cases by a specially trained full-time media relations officer.
11. (Recommendation 14) A major case management system is required to ensure:
- a. that one single specially trained officer is in clearly in charge of and accountable for the planning, strategy, and execution of the arrest and interview, as well as all other aspects of the investigation;
  - b. that a detailed running synopsis of the investigation be maintained in a form that can be quickly adapted as a core document as a basis for the preparation of a search warrant and other legal documentation;
  - c. that all officers involved in the arrest and questioning of a suspect, from the most senior to the most junior, are aware of the legal requirements for a valid arrest and questioning and the legal consequences of failing to comply with those requirements;
  - d. that the officer in charge be responsible for the co-ordination of all advice and direction given to the arresting and interviewing officers.
12. (Recommendation 15) The officers who conduct major searches should be selected based on their experience and expertise, with an effort to combine officers and other persons selected to assist with different perspectives. A second team of searchers should be sent in after the first group has exhausted all apparent possibilities.
13. (Recommendation 16) Sexual assault case management systems and sexual assault investigation training are required to emphasize:
- a. sensitivity to the special concerns of sexual assault survivors and the potential for revictimization through the investigative, prosecution, and judicial processes;
  - b. continuity of contact between investigator and victim;
  - c. availability of victim support services;
  - d. interview techniques that encourage full disclosure of the assault and its circumstances;
  - e. keeping victims informed of the progress of the investigation and the case.
14. (Recommendation 17) A province-wide coordinated response to serial predators is required, based on the CISO model of a centrally supported police cooperative with additional interdisciplinary advice and support but without the creation of a new agency or the attraction of any bureaucratic baggage.
15. (Recommendation 18) A coordinated case management system is required that transcends any localized mindset, discourages tunnel vision, recognizes that the capture of a serial predator involves a provincial public interest wider than the interest of any single community or police force, and encourages unified investigations with clearly defined leadership and accountability.
16. (Recommendation 19) A co-ordinated early recognition system is required to recognize links between crimes early enough to pool information and converge the separate investigations onto the same target, a system based on:
- a. more effective utilization of CPIC zone alerts and CPIC offline searches;
  - b. mandatory ViCLAS reporting by all Ontario police forces, by regulation under the Police Services Act, supported by training, reinforcement, and any resources necessary to support expanded ViCLAS reporting;
  - c. the use of the Chief Coroner's records of unidentified human remains, homicides, and coroners' death investigations organized on a systematic database;

- d. systematic use of other potential linkage indicators such as composite drawings, forensic tests conducted by CFS, and profiling;
- e. training for major case managers and senior investigators to use all potential linkage indicators;
- f. case management systems that heighten the awareness, of uniformed officers and investigators throughout a police force, to linkage indicators.

17. (Recommendation 20) A centrally supported organizational structure is required, based on co-operation among individual police forces, that combines unified leadership across police jurisdictions with organized case management procedures and interdisciplinary support from forensic scientists and other agencies. The recommended structure is as follows:

- two levels of coordination including a Board of Directors and an Executive Committee;
- the Board of Directors
  1. based on the CISO police co-operative mode;
  2. composed of twelve police chiefs chosen by the OACP and/or the CISO governing body, the Chief Coroner, the Director of the CFS, the Assistant Deputy Solicitor Generals for Policing Services and Public Safety;
  3. supported by existing structures without the creation of any new bureaucratic agency or the attraction of bureaucratic baggage;
  4. to implement the policies and maintain the framework that will ensure the smooth operation of the recommended major case management system for multi-jurisdictional investigations of serial predators;
  5. to resolve any conflicts that cannot be resolved by the officer in charge;
  6. to be directly accountable to the Solicitor General for all financial issues but independent in relation to police operations and investigations;
  7. to operate on the basis of standard memoranda of agreement entered into voluntarily by all police forces in Ontario;
  8. to be administratively supported by a small staff group similar or identical to the present CISO structure;
- the Executive Committee:
  - a small group of Board members accountable to the Board;
  - responsible for the triggering mechanism, based on the ViCLAS definition, which launches the co-ordinated investigation in a particular case: all abductions, homicides, sexual assaults and attempts or attempts that appear to be sadistic or sexual or predatory in nature, apparently random, motiveless or are known or suspected of being part of a series, particularly where more than one police jurisdiction is involved and where the circumstances suggest a public safety interest beyond the community or communities directly involved;
  - responsible for the resource decisions, financial accountability, and general oversight of specific investigations, leaving the actual investigation itself to the officer in charge;
  - to include as ad hoc members, when dealing with a specific investigation, the chiefs or their designates of the individual forces involved, and the chief of the senior officer in command, if he does not come from one of the involved forces;
  - responsible for selecting and, in the case of irreconcilable differences, the removal of the senior officer in charge and for major resource and policy decisions, but not to interfere with the investigative authority or accountability of the senior officer in charge;
  - one single senior case manager or officer clearly in charge and accountable, drawn from a cadre of approximately twelve senior and experienced criminal investigators preselected by the Board;

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- specially trained in major case management and inter-jurisdictional investigations;
  - accountable to the Board and the Executive Committee for financial issues and the ultimate success or failure of the investigation, but personally and directly in charge of the investigation at all times;
  - an Interdisciplinary Advisory Committee to ensure a consistently high level of continuing technical, legal and forensic advice, selected jointly by the Senior Case Manager and the Executive Committee, to advise the senior officer in charge but not to manage the investigation;
  - a Support Team composed of a full-time media officer, crime analysts, profilers, computer technicians, an officer manager, clerical staff including data entry staff, and a budget officer;
  - Lead Investigators for the individual cases, who will have received essentially the same training package as the senior case manager.
18. (Recommendation 21) Standard case management procedures are required of the kind described in the Major Case Management Manual developed by the Canadian Police College, customized to the Ontario police, legal and forensic environments.
19. (Recommendation 22) Early approval of one single uniform computerized case management system for mandatory use in all serial predator investigations and all major sexual assault and homicide cases that could potentially fit the ViCLAS definition or the triggering definition and turn into a serial predator investigation:
- a. with capabilities similar to the CASEFILE! System;
  - b. agreed upon quickly by the Ontario police community as the one single preferred uniform package;
  - c. updated regularly under the direction of the Board and the Executive Committee;
  - d. with its uniformity and ability to share information guaranteed by a strong prohibition against “improvements” or tinkering by individual forces that might improve it 10% and destroy 90% of its value as a common, uniform, system for information-sharing;
  - e. supported by basic computer training for all investigators who will use the programme and advanced training for those at the centre of the investigation.
20. (Recommendation 23) Eventual standardization is desirable of other police information and record systems, information standards, and mainframes, of the kind recommended at the Fire College Conference; such work must not interfere with the immediate approval of a single common computerized case management information system of the kind represented by CASEFILE!
21. (Recommendation 24) Specialized training is required as one of the foundations of a new defence against serial predators, particularly in the following areas:
- i. Major case management and inter-jurisdictional investigation training for specially selected senior officers in command, senior investigators, and members of interdisciplinary support teams, to include topics such as
    - special problems of serial predator investigations;
    - special problems of inter-jurisdictional investigations;
    - media liaison;
    - victim support;
    - stress management;
    - information management;
  - ii. Specialized training for criminal investigators in homicide and sexual assault investigations and crime scene identification.

22. (Recommendation 25) An organized system is required under the direction of the proposed Board of Directors to ensure that our law enforcement agencies learn from the mistakes of the past not only in the Mr. Bernardo and other serial predator investigations but also the problems and solutions identified by Ontario coroners' juries.
23. (Recommendation 26) Funding and support for serial predator investigations is required under s. 9 of the Treasury Act, administered through the proposed Board of Directors and Executive Committee through machinery based on the present CISO funding model. This funding cannot be used simply for the purpose of cost relief for investigations that should be funded locally.
24. (Recommendation 27) Funding is required for the training packages, the establishment and maintenance of a reasonable turnaround time for DNA testing, and the start-up and maintenance of the proposed system. The necessary funds are modest compared with the human and financial costs of failing to increase to a more reasonable level the systems of public protection against serial predators. It would be institutionally reckless to fail to do so.

### **3.4. Commission of Inquiry into the Actions of Canadian Officials in Relation to Maher Arar (2006)<sup>224</sup>**

Maher Arar is a dual citizen of Canada and Syria residing in Canada. In 2002, he was detained during a layover in the United States, held without charges, and denied access to counsel based on groundless suspicions that he was a member of Al Qaeda. Those suspicions stemmed from information the RCMP had given to the US government. The US government sent him to Syria, where he was detained and tortured for ten months. Syrian officials eventually released him, and he returned to Canada. The Commission of Inquiry led by Justice Dennis O'Connor focused on the RCMP actions relating to Mr. Arar prior to his detention in the United States, his detention and removal to Syria, his imprisonment in Syria, and events after his return to Canada.

In the Report, Justice O'Connor addressed cooperation between the RCMP and other Canadian police forces. He noted the dangers of investigative silos and referred to the reviews of the Guy Paul Morin and Mr. Bernardo investigations (summarized in sections 3.1. and 3.3. above), which "revealed the dangers inherent in police forces not working together or sharing information."<sup>225</sup>

Justice O'Connor also noted that the strategic focus on Muslim and Arab communities following 9/11 requires national security investigators to have social contact training on these communities:

Enhanced understanding of the community will allow investigators to more effectively evaluate information and determine what is important and what is not, as well as the significance of actions and associations. Investigators will be better placed to avoid relying on stereotypes about race, religion or ethnicity in investigations. As a result, they will be able to distinguish between those who pose a threat in terms of committing crimes and those who are merely sympathetic to political or religious views or ideological goals. In this way, resources can be focused on real threats to the security of Canada.

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<sup>224</sup> "Report of the Events Relating to Maher Arar: Volume I, Analysis and Recommendations." Commission of Inquiry into the Actions of Canadian Officials in Relation to Maher Arar (September 2006), [https://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher\\_arar/07-09-13/www.ararcommission.ca/eng/AR\\_English.pdf](https://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf). See also "Report of the Events Relating to Maher Arar: Volume IIA, Factual Background" and "Report of the Events Relating to Maher Arar: Volume IIB, Factual Background."

<sup>225</sup> "Report Relating to Maher Arar: Analysis and Recommendations," p. 317.

[...]

Social context education can also have the practical advantage of making it easier for investigators to conduct interviews, gain information within various minority communities and obtain co-operation and support. Engaging in a more effective dialogue with those in the community who can assist the RCMP in its investigations can facilitate efforts in fulfilling its national security mandate.<sup>226</sup>

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 2) The RCMP should continue to engage in integrated and co-operative operations in national security investigations, but agreements or arrangements in this respect should be reduced to writing.
  - a. The RCMP's integrated policing initiatives with other Canadian police forces are necessary and beneficial and should continue.
  - b. While respecting their different mandates, the RCMP and CSIS should continue to co-operate with one another and expand upon the ways in which they do so.
  - c. The RCMP should continue to adhere to and refine its policy of cooperating with other federal agencies or departments involved in national security investigations.
  - d. The RCMP should continue to work co-operatively with foreign agencies in pursuing its law enforcement mandate in national security investigations.
  - e. The RCMP's agreements or arrangements with other entities in regard to integrated national security operations should be reduced to writing.
2. (Recommendation 3e) The RCMP should continue and expand upon its social context training, which is necessary to be able to conduct efficient investigations while ensuring fairness to individuals and communities.
3. (Recommendation 8) The RCMP should ensure that whenever it provides information to other departments and agencies, whether foreign and domestic, it does so in accordance with clearly established policies respecting screening for relevance, reliability, and accuracy and with relevant laws respecting personal information and human rights.
4. The RCMP should maintain its policy of screening information for relevance before sharing it.
5. The RCMP should ensure that information provided to other countries is reliable and accurate and should amend its operational manual accordingly.
6. Information should also be screened by the RCMP for compliance with the applicable law concerning personal information before it is shared.

### **3.5. Forsaken: Missing Women Commission of Inquiry (British Columbia, 2012)<sup>227</sup>**

This inquiry was struck in 2010 to examine the police investigations of women missing from the Downtown Eastside (DTES) in Vancouver between 1997 and 2002, and the Crown's decision to stay proceedings against Robert Pickton in 1998. Women working in the sex trade in the DTES went missing over the course of several years. Mr. Pickton, who owned a farm in Port Coquitlam, BC, eventually confessed to an undercover officer to having killed 49 women and was convicted

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<sup>226</sup> "Report Relating to Maher Arar: Analysis and Recommendations," p. 327.

<sup>227</sup> "Forsaken: The Report of the Missing Women Commission of Inquiry" (the "Oppal Report"). Submitted to the Minister of Justice and Attorney General of British Columbia (November 2012), <https://missingwomen.library.uvic.ca/index.html%3Fp=30.html>.

of killing six women. The remains of dozens of women were found on his farm. The Commissioner, the Honourable Wally Oppal, QC, concluded that “the initiation and conduct of the missing and murdered women investigations were a blatant failure.”<sup>228</sup>

In the discussion of his mandate, Mr. Oppal noted the difficulty provincial authorities have in governing the conduct of the RCMP’s contract policing services, a difficulty that extends to public inquiries established by provincial governments:

[T]he RCMP performs three separate policings in British Columbia: federal, provincial and municipal. An unclear delineation between federal and provincial powers in the contracts with the RCMP complicates the ability of the province to assert legislative or regulatory control over the RCMP. In the past, provincial inquiries into RCMP activities have been met with litigation that challenged the jurisdiction of the province. On occasion, these cases have reached the Supreme Court of Canada, and the holdings that resulted are generally seen as undermining the authority of the province with respect to policing services contracted to the RCMP.

In brief, early decisions of the Supreme Court have held that Parliament’s authority to establish and manage the RCMP is unquestioned, and as such, it is “clear that no provincial authority may intrude on its management.” Internal RCMP management or administration which lies beyond provincial jurisdiction has included the methods of investigation used, the punishment and discipline of RCMP officers, and the regulations and practices of the RCMP. Courts have deemed it beyond the powers of a provincial inquiry even to make recommendations on the regulations and practices of the RCMP. However, members of the RCMP have, at all times, remained subject to the provincial enforcement of criminal law for any criminal acts committed by them, whether or not they were acting as RCMP officers at the time.

In a more recent decision of the Supreme Court, the relationship between the province and the RCMP as a contracted provincial police force was clarified. It was held that “there is no doubt that the RCMP remains a federal institution at all times,” even when it is acting under a contract with the province. However, there is no transfer of the province’s constitutional responsibility for the administration of justice in the province. When acting on the province’s behalf, the RCMP thus must also fulfill the constitutional and Charter obligations of the province. The question that follows is whether it should be the RCMP or the province that elects the manner and standard to which those obligations are met.

My mandate under paragraphs 4(c) and 4(d) clearly require me to focus on policing in British Columbia as a whole. Furthermore, representatives of the RCMP and counsel to the Government of Canada have stated that they welcome my recommendations for reform. Thus I cannot trench through a “direct focus or effect” upon areas of management or administration of the RCMP, given that it is a federal agency. I can, however, make recommendations relating to the changes I consider necessary respecting the initiation and conduct of investigations in British Columbia of missing women and suspected multiple homicides, including those involving more than one investigating organization.<sup>229</sup>

In March 1997, Mr. Pickton was charged with attempted murder, assault with a weapon, unlawful confinement, and aggravated assault. The victim, referred to in the Report by the pseudonym “Ms. Anderson,” told police that Mr. Pickton had picked her up in the Downtown East Side and offered her money for a sex act if she went with him to his home in Port Coquitlam. After they had sex in his trailer, he handcuffed her left wrist and tried to handcuff her to another object. She resisted and he attacked her with a board or stick. She grabbed a knife and slashed him. She

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<sup>228</sup> “Forsaken,” Executive Summary, p. 26.

<sup>229</sup> “Forsaken,” Volume I, pp. 173–74 (citations omitted).

tried to leave, and he continued to assault her outside. He got the knife and stabbed her in the stomach. She ran away and hailed a car driving near the property. Ms. Anderson's injuries were severe and life-threatening; she had to be revived twice on the operating table.

The police interviewed Ms. Anderson once, after searching Mr. Pickton's trailer. Mr. Pickton was eventually charged and released on bail. There was no weapons prohibition in the bail terms proposed by the Crown, even though this term is standard for attempted murder and Mr. Pickton was known to associate with Hell's Angels. Mr. Pickton told investigators that Ms. Anderson had a dangerous outburst, and he handcuffed her to get her under control.

Mr. Oppal noted that the search of Mr. Pickton's trailer and the subsequent interview with Ms. Anderson revealed information that would suggest that Mr. Pickton's assault on Ms. Anderson was not a unique event. For example, there was a woman's bra in the trailer that was not Ms. Anderson's; three hairbrushes, even though Mr. Pickton was balding; he had refused to let Ms. Anderson use the phone or stop on the way to use the bathroom; Ms. Anderson told police that there were lots of girls missing from downtown and she "just [knew] there's broads on that property";<sup>230</sup> and there were many unused condoms in the trailer. Police did not conduct a second or more thorough search of the property after Ms. Anderson suggested he had killed other women. They were aware that he had been investigated seven years before for a rape and stabbing in Surrey but did not include that information in the report to Crown counsel. The Surrey police reported that the file no longer existed. The Coquitlam police did not make any further inquiries into Mr. Pickton's activities, interview neighbours, or take any other investigative steps during this investigation. They did place a warning on Canadian Police Information Centre (CPIC) that Mr. Pickton was a potential danger to women, particularly women in the sex trade. They did not issue a warning to those women.

The Crown reviewed the file and decided that Mr. Pickton's version of events could be true and considered the file a "he said, she said" case. The Crown met with Ms. Anderson once, two weeks before the trial, and decided to stay the charges in January 1998 on the basis that Ms. Anderson, who was addicted to heroin, would not be a useful witness. The test in BC for continuing with a charge at the time was "substantial likelihood of conviction." However, Crown policy permitted prosecutions to go forward where there is a "reasonable prospect of conviction" in cases of "high risk violent or dangerous offenders, or where public safety concerns are of paramount consideration."<sup>231</sup> The Crown took no steps to attempt to assist Ms. Anderson before the trial or otherwise take steps to have the trial go ahead. Following the stay, one of the Coquitlam RCMP officers continued to investigate Mr. Pickton from time to time.

Dozens of women went missing from the DTES during this period. In 1998, there was a hang-up 911 call from Mr. Pickton's trailer, which police concluded was an error. By 1999, following pressure from the community, the Vancouver Police Department recognized that there was a problem with missing women. Over the following years, various poorly resourced investigation teams and projects were established and abandoned. Mr. Pickton was considered a prime suspect from 1999 onwards, in part due to a second-hand report that a woman said she witnessed Mr. Pickton skinning a body hanging in his barn. One man reported in 1998 that Mr. Pickton was disposing of body parts into drums that he took to a recycling plant; a year later, other officers saw Mr. Pickton take drums to a recycling plant but did not investigate the contents of a drum. Due to a breakdown in communication, these two pieces of information were never connected. In

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<sup>230</sup> "Forsaken," Volume IIA, pp. 40 and 45.

<sup>231</sup> "Forsaken," Volume IIA, pp. 49 and 70.

2000, Coquitlam RCMP investigators planned to seek a search warrant and authorization to intercept his communications and check the handcuff from the 1998 attempted murder for the DNA of other women. However, the investigation stalled due to resource limitations and direction from management.

In 2001, a joint forces operation involving the RCMP and the Vancouver Police Department focused on the missing women, called "Project Evenhanded," was established. In February 2002, an unrelated Coquitlam RCMP investigation led to a search for weapons on Mr. Pickton's property. Officers discovered items and identification belonging to two of the missing women. A comprehensive search led to the discovery of the DNA of 33 women on the property. Mr. Pickton was charged with 27 counts of first-degree murder and eventually convicted of six counts of second-degree murder; the remaining counts were stayed or dropped.

Mr. Oppal's report detailed numerous problems in the investigations of the missing women. For example, Olivia Williams was reported missing to the Smithers RCMP detachment in the same month Mr. Pickton was charged with attempting to murder Ms. Anderson. There were problems with communications between the RCMP in Smithers, where Ms. Williams' social worker was located, and the Vancouver Police Department, where Ms. Williams was known to engage in the sex trade. It was unclear which agency had conduct of the investigation. After three months, during which no substantive investigation was taken, the Smithers RCMP sent the file to the Vancouver Police Department and closed their file. The Vancouver Police Department did not open a missing persons file until nearly a month later. Police did not investigate tips to completion or use community resources to investigate. Mr. Oppal also noted there was minimal contact between police and Ms. Williams' family unless it was initiated by the family. Ms. Williams is still missing, and it is unknown what happened to her. Mr. Oppal identified similar problems regarding jurisdictions and file transfers in numerous cases he reviewed. Other problems included:

1. Failure to consider the investigation of missing women as urgent, with a number of investigations proceeding at a "glacial pace";<sup>232</sup>
2. Failure to interview the person making the report in a timely way and repeated failure to attend the woman's last known residence;
3. Failure to investigate tips to conclusion, failure to conduct follow-up investigations, and unexplained gaps in investigations, along with a failure to employ an Aboriginal-specific investigation strategy, given the disproportionate number of Indigenous women among the missing;
4. Failure to consistently check CPIC or enter information into CPIC; although investigators did make use of databases such as ViCLAS and child protection databases, they were not always timely, not consistently used, and there were challenges to conducting some searches due to legal and privacy restrictions;
5. A lack of functioning computer information systems to manage the volume of information involved in the investigation, leading to handwritten investigative logs, disorganized files, and a failure to make links between pieces of information;
6. Insistence in Vancouver of confirming a woman was missing before conducting a full investigation;

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<sup>232</sup> "Forsaken," Volume IIB, p. 25.

7. Poor use of community resources in the investigations, including a failure to engage with women in the community, health and social services agencies, and a failure to learn more about the community;
8. Failure to keep in regular contact with the families, including a failure to update them on the status of the investigation; Mr. Oppal found that communication fell “far below a reasonable threshold”<sup>233</sup> and that 911 call-takers and some Vancouver police members and staff made comments that the families found insensitive and degrading.
9. The absence of a consistent policy and practice for dealing with the transfer of missing person files from one jurisdiction to another, causing delays in the investigations, and a lack of clarity about which agency was responsible for the investigation;
10. Failures of communication, reporting, and accountability within investigation teams;
11. Faulty risk analysis and risk assessment, which led to a failure for years to accept that a serial killer was responsible for the missing women. This failure was based in part on erroneous assumptions that because there were no bodies, there was no crime and that the women were transient, and a failure to recognize the risk of serial offenders preying on sex workers;
12. Failure to follow Major Case Management practices and policies, despite the recommendations of the Bernardo Review in 1996 (summarized in section 3.3. above); and
13. Failure of internal review and external accountability mechanisms.

Mr. Oppal noted that a review of 1,400 serial killers over the last century identified the inability to coordinate between multiple police forces as a pitfall in police investigations of these crimes. He noted that “the inability to fully address cross-jurisdictional issues was a critical police failure substantially limiting the effectiveness of the investigations.”<sup>234</sup> He stated:

[I]t is important to keep in mind that the RCMP is a large national organization that carries out multiple policing functions in British Columbia. Many RCMP entities were involved in this case: several RCMP detachments were involved in the missing women investigations, including the Coquitlam RCMP, which took the lead in the Mr. Pickton investigation, and the E Division Major Crime Section, which was involved at various points in time. The Provincial Unsolved Homicide Unit (PUHU), an integrated unit comprised of RCMP and VPD, also played a role. I find that there is evidence of ineffective co-ordination among these entities and between these entities and the VPD.<sup>235</sup>

The multi-jurisdictional nature of the case also caused “linkage blindness,” as investigating officers receiving missing persons reports in RCMP detachments did not always realize a woman’s link to the DTES; if they had, they would then have had to request the VPD to investigate.

After considering the problems in the investigation, Mr. Oppal then turned to the steps police took prevent harm to women in the DTES. He stated, “I conclude that there was a near complete failure of the police to take steps to protect women engaged in the survival sex trade in the DTES until early 2002.”<sup>236</sup> He found the following:

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<sup>233</sup> “Forsaken,” Volume IIB, p. 55.

<sup>234</sup> “Forsaken,” Volume IIB, p. 180.

<sup>235</sup> “Forsaken,” Volume IIB, p. 182.

<sup>236</sup> “Forsaken,” Volume IIB, p. 95.

- The Vancouver Police Department strategy of containing the sex trade to remote and unsafe parts of downtown Vancouver, “where justice did not prevail, where violence against women was made invisible,”<sup>237</sup> made the women more vulnerable to serial predators. Mr. Oppal also strongly condemned the VPD submission that the “real issue” was that women were putting themselves at risk by getting into cars with men as victim blaming.
- The police failed to pursue crime prevention strategies despite the numbers of women going missing. They failed to put proactive teams of officers into the DTES until January 2002. They were focused (eventually) in a general sense on catching the person responsible for the women going missing, but they “did not pay attention to the ongoing threat posed in the DTES.”<sup>238</sup> Mr. Oppal said, “I conclude that this delay is simply unfathomable and reflected the fundamental error of failing to place any real emphasis on prevention, which plagued the entirety of the missing women investigations from the beginning to almost the end” of the investigation.<sup>239</sup>
- The police failed to issue a warning to women in the DTES and publicly downplayed the public fears that a serial killer was at work. Both the Vancouver Police Department and the eventual joint forces operation Project Evenhanded “committed serious errors in failing to provide a specific warning to women in the DTES.”<sup>240</sup> Mr. Oppal found that police would have known about their duty to warn a particular victim group even before the trial judgment in *Jane Doe v. Metro Toronto Police*, and senior police managers would have been discussing that decision after its release in 1998. He found that the Vancouver Police Department and RCMP should have issued two warnings: one to women in the DTES, and one to Indigenous communities across British Columbia, given that a number of the victims came from these communities. One of the investigators wanted to issue a media release in September 1998 to warn women in the community, but management did not permit it. VPD managers justified this decision at the inquiry on the basis that there was no proof there was a serial killer; they did not have sufficient information to provide a targeted and effective warning; and a warning would not have been effective, as the women were rendered incapable of changing their behaviour due to drug addiction. Mr. Oppal stated that this third explanation “reeks of a paternalistic attitude that the police knew better than the women about how they would react to a warning” and was based on ignorance, paternalism, and prejudice.<sup>241</sup> The warning could have led the women to take steps to protect themselves, led to tips to help the investigation, and dissuaded Mr. Pickton from committing more crimes.

Mr. Oppal also found that the police failed to fully exploit other investigative avenues, such as undercover operations, search warrants, and forensic evidence. Mr. Oppal found that these problems were caused by:

1. Systemic bias against the women who went missing, which was a “manifestation of the broader patterns of systemic discrimination within Canadian society and was reinforced by the political and public indifference to the plight of marginalized female victims,”<sup>242</sup> particularly Indigenous women working in the sex trade. He noted that “it is difficult to conceive that the

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<sup>237</sup> “Forsaken,” Volume IIB, p. 96.

<sup>238</sup> “Forsaken,” Volume IIB, p. 98.

<sup>239</sup> “Forsaken,” Volume IIB, p. 100.

<sup>240</sup> “Forsaken,” Volume IIB, p. 100.

<sup>241</sup> “Forsaken,” Volume IIB, p. 102.

<sup>242</sup> “Forsaken,” Volume IIB, p. 217.

people of Vancouver would be as quiet if close to 70 women went missing from a different neighbourhood.”<sup>243</sup>

2. A failure of leadership;
3. Limited and outdated policing systems, approaches and standards, including a lack of provincial co-ordination in respect to missing person investigations and a “parochial and silo-based approach to policing”;<sup>244</sup>
4. Fragmentation of policing in the Lower Mainland of BC and the inadequacy of structures to overcome this fragmentation, leading to a paucity of information-sharing and communication between policing agencies;
5. Inadequate resources, caused by the failure to prioritize the missing women cases;
6. Police culture and personnel problems. The paramilitary, hierarchical structure of both the RCMP and VPD creates turf issues, secrecy, the dilution of information as it goes up the chain of command, a lack of creative problem-solving, and a lack of a challenge culture. Mr. Oppal said the chain of command structure within police institutions is a valid and important tool but was applied too rigidly in the missing women investigations. Mr. Oppal noted the “bureaucratic nature” of decision-making at the RCMP and its striking culture of reluctance to ask another police force for help.<sup>245</sup> He also noted the conflicting evidence before him regarding sexist and racist attitudes among individual officers. He found there was inadequate and inconsistent cultural and social context training, which contributed to errors in the investigation.

Mr. Oppal also noted the obligations of police to respect women’s equality and protect vulnerable members of the community, including women, and the international jurisprudence on police obligations to investigate reports of violence against women and otherwise failing to take violence against women seriously. He stated:

My review of the general duty of non-discrimination in policing and specific police duties to address violence against women makes it clear that the police have an obligation to take steps to prevent violence against women and to ensure effective investigations into crimes of violence against women. The positive nature of this obligation is very clear.<sup>246</sup>

The British Columbia government has published several reports on the implementation of Mr. Oppal’s recommendations, most recently in 2012.<sup>247</sup>

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 4.1) That the Minister of Justice direct the Director of Police Services to undertake equality audits of police forces in British Columbia with a focus on police duty to protect marginalized and Aboriginal women from violence. These audits should be carried out by an external agency and with meaningful community involvement.

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<sup>243</sup> “Forsaken,” Volume IIB, p. 237.

<sup>244</sup> “Forsaken,” Volume IIB, p. 255.

<sup>245</sup> “Forsaken,” Volume IIB, p. 276.

<sup>246</sup> “Forsaken,” Volume I, p. 126.

<sup>247</sup> See “Report in Response to FORSAKEN: The Report of the Missing Women Commission of Inquiry—2021 Status Update.” BC Ministry of Public Safety and Solicitor General (April 2021), <https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/about-bc-justice-system/inquiries/mwci-status-update-2021.pdf>

2. (Recommendation 4.2) That Provincial Government set a provincial standard establishing that police officers have a general and binding duty to promote equality and to refrain from discriminatory policing.
3. (Recommendation 4.5) That Provincial Government adopt a policy statement in the BC Crown Policy Manual requiring that a prosecutor's evaluations of how strong the case is likely to be when presented at trial should be made on the assumption that the trier of fact will act impartially and according to the law.<sup>248</sup>
4. (Recommendation 4.6) That Provincial Government direct the Director of Police Services to consult with the BC Association of Municipal Chiefs of Police, the RCMP, and community representatives to recommend the wording of a statutory provision on the legal duty to warn and a protocol on how it should be interpreted and applied.
5. (Recommendation 4.7) That police forces work with local communities to develop communication strategies for the issuance of warnings that ensure the message is conveyed to community members who are most at risk of the specific threat.
6. (Recommendation 4.9) That Provincial Government develop guidelines to facilitate and support vulnerable and intimidated witnesses by all actors within the criminal justice system based on the best practices identified by the Commission through its review of protocols and guidelines existing in other jurisdictions.
7. (Recommendation 4.10) That police forces integrate into training, performance standards, and performance measurement the ability of police officers to develop and maintain community relationships, particularly with vulnerable members of the community who are often at risk of being treated unequally in the delivery of public services.
8. (Recommendation 4.11) That the BC Association of Municipal Chiefs of Police and the RCMP establish a working group to develop a best practices guide for the establishment and implementation of formal discussion mechanisms to facilitate communication and collaboration that transcends the institutional hierarchy within a police agency.
9. (Recommendation 4.12) That police officers be required to undergo mandatory and ongoing experiential and interactive training concerning vulnerable community members:
  - Active engagement in overcoming biases, rather than more passive sensitivity training (sometimes called anti-oppression training);
  - More intensive and ongoing training in the history and current status of Aboriginal peoples in the province and in the specific community, particularly with respect to the ongoing effects of residential schools and the child welfare system;
  - Training and resources to make prevention of violence against Aboriginal women a genuine priority;
  - Training to ensure an understanding of violence against women in a range of settings including family violence, child sexual exploitation, and violence against women in the

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<sup>248</sup> According to the "Independent Review of the Police and Prosecution Response to the Rehtaeh Parsons Case," submitted to the NS Minister of Justice and Attorney General (October 2015), <https://novascotia.ca/segalreport/Parsons-Independent-Review.pdf>, the directive to Crown prosecutors in Nova Scotia prohibits them from hinging their decisions regarding the prospect of conviction on dubious generalities such as 'juries always believe children' or 'juries never convict police officers.'" (p. 78 of the Independent Review Report, quoting the directive).

- sex trade; in particular, the scenarios used in police training should incorporate issues of cultural sensitivity and violence against women; and
- Training in recognizing the special needs of vulnerable individuals and how to meet those needs, including recognition of a higher standard of care owed by the police to these individuals.
10. (Recommendation 4.13) That the Police Complaint Commissioner, working with police forces across the Province, take steps to develop, promote, and refine informal methods of police discipline, particularly in marginalized communities such as the DTES and with Aboriginal communities.
  11. (Recommendation 4.14) That Provincial Government engage with the RCMP in order to bring them into the provincial complaints process.
  12. (Recommendation 5.9) That the City of Vancouver and the Vancouver Police Department take proactive measures to reduce the number of court warrants issued for minor offences by:
    - Reducing the number of tickets issued and charges laid for minor offences;
    - Developing guidelines to facilitate greater and more consistent use of police discretion not to lay charges; and
    - Increasing the ways in which failures to appear can be quashed early in the judicial process.
  13. (Recommendation 5.10) That courts consider making increased use of diversionary or alternative measures to deal with bench warrants and breaches of conditions. This is in light of the barriers that outstanding warrants have on the ability of vulnerable women who are victims of violent crime to access police services. And that proactive steps be taken to assist women to clear outstanding warrants.
  14. (Recommendation 5.11) That the Minister of Justice consult with the judiciary, police, and community representatives to develop a protocol providing the police with the discretion not to enforce a warrant in a circumstance where a sex trade worker is attempting to report a violent crime.
  15. (Recommendation 5.13) That the BC Association of Municipal Police Chiefs and the RCMP, with support from the Director of Police Services, should develop a protocol containing additional measures to monitor high-risk offenders, including recommendations for the efficient and timely sharing of information.
  16. (Recommendation 6.3) That Provincial Government provide additional funding to Aboriginal women's organizations to create programs addressing violence on reserves, so that fewer women and youth are forced to escape to urban areas.
  17. (Recommendation 6.4) That Provincial Government provide additional funding to Aboriginal women's organizations to provide more safe houses and counselling programs run for and by Aboriginal women and youth.
  18. (Recommendation 7.1) That the provincial standards be developed by the Director of Police Services with the assistance of a committee consisting of representatives of the BC Association of Municipal Police Chiefs, the RCMP, representatives of community and Aboriginal groups, and representatives of families of the missing and murdered women.
  19. (Recommendation 7.2) That proposed provincial missing persons standards include at least 15 components:
    - Definition of "missing person";
    - Criteria for the acceptance of reports;

- Jurisdiction;
  - Missing Person Risk Assessment Tool;
  - Provincial Missing Person Reporting Form;
  - Standards related to interaction with family/reportees;
  - Initial steps—background information;
  - Supervisory responsibility/quality control;
  - Forensic evidence standards;
  - Coroners' Liaison;
  - Monitoring outstanding missing person cases;
  - Automatic annual review of unsolved cases;
  - Closing missing person files;
  - Prevention and intervention; and
  - The role and authority of the BC Police Missing Persons Centre (BCPMPC).
20. (Recommendation 7.3) That the provincial standards require a proactive missing persons process whereby police must take prevention and intervention measures including “safe and well” checks when an individual is found.
21. (Recommendation 7.4) That best practice protocols be established for (1) enhanced victimology analysis of missing persons, (2) investigative steps in missing person cases, (3) collaborative missing person investigations collection, (4) storage and analysis of missing persons data, and (5) training specific to missing person investigations.
22. (Recommendation 7.5) That Provincial Government establish a provincial partnership committee on missing persons to facilitate the collaboration of key players in the ongoing development of best practice protocols for missing person cases. The committee should be chaired by a senior government official and include representatives of the missing and murdered women’s families, Aboriginal organizations, community groups, service providers, police, and Victim Services.
23. (Recommendation 7.6) That Provincial Government establish an agency independent of all police agencies with the purposes to include coordinating information, identifying patterns, establishing base rates, checking on police investigations, ensuring accountability for linked interjurisdictional series,<sup>249</sup> and warning the public. It should provide oversight and analytic functions, but it should not be an investigating entity.
24. (Recommendation 7.7) That provincial authorities create and maintain a provincial missing person website aimed at educating the public about the missing persons process and engaging them in proactive approaches to prevention and investigation.
25. (Recommendation 7.8) That provincial authorities establish a provincial 1-800 phone number for the taking of missing person reports and accessing case information.
26. (Recommendation 7.9) That provincial authorities develop an enhanced, holistic, comprehensive approach for the provision of support to the families and friends of missing persons. This should be based on a needs assessment carried out in consultation with the provincial partnership committee on missing persons.
27. (Recommendation 7.11) That the provincial partnership committee develop a proposal for either an enhanced BCPMPC to meet additional responsibilities relating to the needs of members of the public and, in particular, reportees; or to create an independent civilian-based agency for this purpose.

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<sup>249</sup> This wording has not been changed from the original.

28. (Recommendation 8.1) That Provincial Government enact missing persons legislation to grant speedy access to personal information of missing persons without unduly infringing on privacy rights. I recommend the adoption of single-purpose legislation, as in Alberta and Manitoba, with a provision for a comprehensive review of the operation of the Act after five years.
29. (Recommendation 8.2) That Provincial Government mandate the use of Major Case Management (MCM) for major crimes and that the Director of Police Services develop these MCM standards in consultation with the police community and through a review of best practices in other jurisdictions.
30. (Recommendation 8.3) That the Director of Police Services mandate accountability under the MCM standards by requiring that police forces:
  - Provide an explanation as to why MCM was not used for a “major crime” in an annual report to the Director of Police Services;
  - Notify the Director of Police Services of all “major crime” investigations that are not under active investigation and have remained open for more than one year. Upon receipt of such notification, the Director will appoint another police department to conduct an independent audit of the prior investigation and conduct such additional investigatory steps as it deems necessary, and report its finding to the Director and the originating police agency; and
  - Conduct annual internal audits of a statistically valid random selection of MCM investigations to ensure proper compliance with the model.
31. (Recommendation 8.4) That issues related to a single electronic MCM system for British Columbia, as well as compatibility with cross-Canada systems, be reviewed as part of the consultation on MCM standards set out above.
32. (Recommendation 10.1) That the Director of Police Services mandate provincial standards for multi-jurisdictional and multi-agency investigations to be incorporated into the provincial MCM standards [...]
33. (Recommendation 10.2) That the Director of Police Services consult with the BC Association of Police Chiefs and the RCMP to create a protocol or framework for multi-jurisdictional major case investigations to ensure the timely and seamless implementation of multi-agency teams, including a provision for an independent panel to resolve disputes regarding when the protocol should be triggered.
34. (Recommendation 10.3) That Provincial Government commit to moving expeditiously to implement a regional Real Time Crime Centre.
35. (Recommendation 11.1) That the accountability structure for the Greater Vancouver police force incorporate a holistic approach that provides oversight on both an individual and systemic level and is fully responsive and responsible to the communities it serves.
36. (Recommendation 11.3) That additional steps need to be taken to ensure representation of vulnerable and marginalized members and Aboriginal peoples on police boards.
37. (Recommendation 11.4) That police boards have access to greater resources from the Division of Police Services to gather and analyze information to enable them to better carry out their oversight functions.
38. (Recommendation 12.1) That Provincial Government appoint an independent advisor to serve as a champion for the implementation of the Commission’s recommendations. This appointment should take effect within 12 weeks of release of the report.

### 3. COMMUNICATIONS AMONG AND WITHIN LAW ENFORCEMENT AGENCIES

39. (Recommendation 12.2) That the independent advisor work collaboratively with representatives of Aboriginal communities, the DTES, and the victims' families in the implementation process.

#### 4. COMMUNICATIONS WITH COMMUNITY: CONTEMPORANEOUS RESPONSE TO VICTIMS AND COMMUNITY; EMERGENCY ALERTS

The Order in Council directs the Mass Casualty Commission to examine “communications with the public during and after the event, including the appropriate use of the public alerting system established under the Alert Ready program” ((b)(v)) and “information and support provided to the families of victims, affected citizens, police personnel and the community” ((b)(xi)). The Alert Ready program was not used during the events of 18 and 19 April 2020.

##### 4.1. Review of the Investigation of Sexual Assaults, Toronto Police Service (Toronto Audit Services, 1999)<sup>250</sup>

*Doe v Metropolitan Toronto (Municipality) Commissioners of Police*<sup>251</sup> was a 1998 decision of the Superior Court of Justice in Ontario that held that Metropolitan Toronto Police had breached their common law duty to warn a woman known as Jane Doe of a rapist known to be targeting women in her neighbourhood. Following the decision, the City of Toronto asked its Auditor, Jeffrey Griffiths, to conduct an independent review of the Toronto Police Service’s investigation of sexual assaults.<sup>252</sup>

Paul Douglas Callow sexually assaulted four women in their apartments at knifepoint in the Church/Wellesley area of Toronto between December 1985 and July 1986. Mr. Callow entered each apartment through the balcony. Police did not warn women in the area. Mr. Callow then raped Jane Doe in her balcony apartment. She sued the Metropolitan Toronto Police Force. The Ontario Divisional Court confirmed that her pleadings disclosed causes of action in torts and under the *Canadian Charter of Rights and Freedoms*.<sup>253</sup>

After the trial, Justice MacFarland noted that following the first two attacks, the police relied on stereotypes about victim responses and asked inappropriate questions of the victims regarding their previous sexual partners. They concluded that the first attacker was the victim’s boyfriend and that the second attack was a false report. One of the officers in question had taken a sexual assault investigators’ course a month before he drew these conclusions; Justice MacFarland noted that “one can only conclude that the course was ineffective in influencing his views in relation to the crime of sexual assault.” After two more attacks in the area, in very similar circumstances, it appears the police came to accept that there was in fact a serial rapist in the area. Police took some steps to alert other police of the possibility of a serial rapist and increased the focus on this neighbourhood during night shifts.

Jane Doe lived in a second-floor apartment with a balcony, three blocks south of the second, third, and fourth attacks. Mr. Callow attacked her on 24 August 1986. Police who interviewed Ms. Doe

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<sup>250</sup> “Review of the Investigation of Sexual Assaults: Toronto Police Service.” Toronto Audit Services (October 1999), [https://walnet.org/jane\\_doe/griffiths-991025.pdf](https://walnet.org/jane_doe/griffiths-991025.pdf)

<sup>251</sup> 1998 CanLII 14826 (ON SC), <https://canlii.ca/t/1w9kn>. The CanLII version of this decision does not contain page numbers or paragraph numbers, so references are not footnoted here.

<sup>252</sup> “Metropolitan Toronto” was the collective term for the City of Toronto and several other municipalities at the time of the Jane Doe trial. In 1998, the municipalities were merged to become the City of Toronto. The police force changed its name to Toronto Police Service.

<sup>253</sup> *Doe v Metropolitan Toronto (Municipality) Commissioners of Police (Div Ct)*, 1990 CanLII 6611 (ON SC), <https://canlii.ca/t/q1kf7>, leave to appeal denied, 1991 CanLII 7565 (ON CA), <https://canlii.ca/t/ggix6>.

told her that they did not warn women in the neighbourhood because they would become hysterical or panic, the rapist would flee, and the investigation would be compromised. Ms. Doe wanted to warn other women in the area, but she was told that if she did, she could be charged for interfering in a police investigation. Police told tenants in local buildings that there had been a number of break-and-enters in the area; they were directed specifically not to mention the sexual assaults. Police then engaged in a stakeout of buildings in the area, with directives not to break cover unless they saw someone climbing a balcony. The women in those buildings were given no warning. Justice MacFarland concluded that the police were using these women as “bait,” without their knowledge or consent, to attract the predator.

Mr. Callow was identified as a suspect by chance, after he was arrested for assaulting his wife. His wife told the probation officer responsible for his pre-sentence report that he had committed a rape following a break-and-enter in Vancouver and was still committing break-and-enters. They lived in the Church/Wellesley area. The probation officer contacted the division investigating the balcony attacks to confirm Mr. Callow’s criminal record. Police then discovered that he had been arrested for raping a woman on Wellesley Street five years earlier, but charges had not proceeded. Callow was arrested and pleaded guilty to all five rapes. Justice MacFarland noted that the fact that the Sexual Assault Coordinator’s office was not aware of Mr. Callow’s arrest for assaulting his wife indicated that the force as a whole did not understand that sexual assault is not about sex; it is about violence against women and anger. She said, “Had the force coordinated efforts to keep track of any and all acts of violence against women, they may have been aware of Callow’s existence much sooner than they were.”

Justice MacFarland found that the investigation was given less priority than an earlier investigation involving a perpetrator known as the Annex Rapist because the victims were “merely raped” by a “gentleman rapist” and not subjected to other additional violence.<sup>254</sup> She found that the investigating officers believed that if they issued a warning, the women in the area would become hysterical and panic and that the investigation would thereby be jeopardized. A meaningful warning could and should have been given to the women at particular risk. Had Ms. Doe been aware that a serial rapist was in the neighbourhood and using balconies to enter apartments, she would have taken steps to protect herself and most probably not been raped.

Justice MacFarland noted that the Police Act in Ontario at the time stated that “members of police forces... are charged with the duty of preserving the police, preventing robberies and other crimes...”<sup>255</sup> She also noted that police have a common law duty to protect life and property. The

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<sup>254</sup> Justice MacFarland put these terms in quotation marks, quoting another document, and it is clear from the context that she meant them ironically.

<sup>255</sup> The Nova Scotia Police Act provides that the provincial police and municipal police “shall provide policing services including

- (a) crime prevention;
- (b) law enforcement;
- (c) assistance to victims of crime;
- (d) emergency and enhanced services; and
- (e) public order maintenance.”

This provision also applies to RCMP divisions providing provincial policing services. See ss. 31(1), 34(4), and 35(3). The Act also provides in s. 42(2) that the “authority, responsibility and duty of a member of a municipal police department includes

- (a) maintaining law and order;
- (b) the prevention of crime;
- (c) enforcing the penal provisions of the laws of the Province and any penal laws in force in the Province;
- (d) assisting victims of crime;
- (e) apprehending criminals and offenders who may lawfully be taken into custody;

law was clear that the police have a duty to warn citizens of foreseeable harm, in order to protect them. Justice MacFarland stated that in some circumstances, the police might reasonably conclude that a warning would cause greater harm than it would prevent by, for example, causing general and unnecessary panic. She noted, however, that the duty to protect would remain in those circumstances but would have to be accomplished by other means. Here, the police neither warned Ms. Doe or any other woman from the danger, nor did they take steps to protect these women. They made this decision “in the face of the almost certain knowledge that the rapist would attack again and cause irreparable harm to his victim.” This was irresponsible and grossly negligent. There was no evidence that could suggest that no warning should have been given in the circumstances of this case. The police were therefore liable to Ms. Doe in damages.

On the *Charter* issues, Justice MacFarland found that the Metropolitan Toronto Police Force (MTPF) had been aware for more than a decade before Ms. Doe was attacked that it had serious problems in its investigation of sexual assault, including a failure to treat survivors sensitively, a lack of effective training of officers, a lack of coordination of investigations, and a lack of supervision. Justice MacFarland noted that the Force had repeatedly assured the public and individuals with complaints that these problems would be eliminated, yet the status quo remained. She stated:

Every police officer who testified agreed that sexual assault is a serious crime, second only to homicide. Yet I cannot help but ask rhetorically—do they really believe that, especially when one reviews their record in this area? It seems to me it was, as the plaintiff suggests, largely an effort in impression management rather than an indication of any genuine commitment for change. [...]

Although the MTPF say they took the crime of sexual assault seriously in 1985–86 I must conclude, on the evidence before me, that they did not. [...]

The problems continued and because among adults, women are overwhelmingly the victims of sexual assault, they are and were disproportionately impacted by the resulting poor quality of investigation. The result is that women are discriminated against and their right to equal protection and benefit of the law is thereby compromised as the result.

In my view the conduct of this investigation and the failure to warn in particular [were] motivated and informed by the adherence to rape myths as well as sexist stereotypical reasoning about rape, about women and about women who are raped. The plaintiff therefore has been discriminated against by reason of her gender, and as the result, the plaintiff's rights to equal protection and equal benefit of the law were compromised.

Justice MacFarland also found that the police adopted a policy that favoured the apprehension of a criminal over her protection as a targeted rape victim. They used her as “bait” without her knowledge or consent and therefore knowingly placed her security at risk. This also stemmed from the discriminatory and stereotypical beliefs they had. By exercising their discretion in their investigation in a discriminatory and negligent way, the police also deprived Ms. Doe of her security of the person under section 7 of the Charter. There was no attempt to justify this conduct under section 1. Justice MacFarland awarded Jane Doe damages of more than \$220,000 and made a declaration that the defendants violated her sections 7 and 15(1) rights under the Charter.

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- (f) laying charges and participating in prosecutions;
  - (g) executing warrants that are to be executed by peace officers;
  - (h) subject to an agreement respecting the policing of the municipality, enforcing municipal bylaws within the municipality; and
  - (i) obeying the lawful orders of the chief officer,
- and the person shall discharge these responsibilities throughout the Province.

The City of Toronto Auditor, Jeffrey Griffiths, released his review of the Toronto Police Service's sexual assault investigations in 1999. Mr. Griffiths worked with an Audit Reference Group, with membership from the Committee on the Status of Women, the Toronto Rape Crisis Centre, the Metro Action Committee on Violence Against Women, and other women's organizations. The Reference Group assisted with staffing the review, identifying experts, and suggesting recommendations. The mandate of the review initially included domestic violence, but the auditor determined that it would not be practical or possible to include that issue in its report. The focus was not on the interviewing of suspects but on police interactions with victims.

Mr. Griffiths noted that this was to his knowledge the first audit of the investigation of sexual assaults by police in North America and possibly the world. He emphasized the importance of creating mechanisms to ensure that the recommendations were implemented, noting Justice MacFarland's finding that the assertions by police that they were making changes to improve their response to sexual assaults were merely "impression management" rather than a reflection of genuine commitment for change.<sup>256</sup>

The Auditor identified a number of changes the TPS had made to its approach to sexual assault investigations in recent years, in part in response to Justice Campbell's report on the Mr. Bernardo investigation (summarized above in section 3.3.). These included the formation of a Sexual Assault Squad, the creation of a Behavioural Assessment Unit within that squad, which focuses on stalking, criminal harassment, and similar conduct, specialized sexual assault units in two divisions, community response units, a program to keep in contact when high-risk offenders are released from federal prisons, and sexual assault training of significant numbers of officers in the field. However, he also identified a number of areas that required change, including the following:

1. The Sexual Assault Squad focused only on sexual assaults committed by strangers, which is a small portion of sexual assaults. It should focus on all penetrative or attempted penetrative sexual assaults, regardless of the relationship of the perpetrator with the victim. It operates in isolation from other police investigations relating to violence against women. Mr. Griffiths cited Justice MacFarland's comments about the Force's failure to connect Callow's assault on his wife to the sexual assaults, and recommended a process be put in place to link domestic violence incidents with sexual assault investigations.
2. The process of recruitment to the Sexual Assault Squad had failed to ensure its investigators had specific skills and aptitudes.
3. The Sexual Assault Squad website read as a public relations exercise for the squad rather than as a source of information for women who have been sexually assaulted, including information about the role of the squad, support services such as the Toronto Rape Crisis Centre and the Victim Services Program.
4. The initial interview with women who have been sexually assaulted is critical to the woman's experience with police, but often does not comply with procedure. In addition, frontline officers do not have specific guidance on their responsibilities during this interview or on how to conduct an interview with a woman with special needs.
5. A review of a random selection of occurrence reports prepared by investigators and first-response officers showed clearly that in some cases interviews had not been conducted properly, including some completed by Sexual Assault Squad members. Some were incomplete and contained conclusions with no basis. Some contained inappropriate language.

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<sup>256</sup> "Review of the Investigation of Sexual Assaults: TPS," pp. 19 and 31.

There had been no apparent review or discussion with the officers who prepared these reports. A number of reports classified complaints as unfounded, in the absence of information substantiating that conclusion (although Mr. Griffiths acknowledged that the issue may have been with the sufficiency of information in the occurrence report rather than with the conclusion that the assault complaint was unfounded.)

He concluded that decisions relating to whether a case should be dismissed should not be taken by the first officer on the scene; rather, it should be made by qualified sexual assault investigators.

6. In a number of cases in which women did not wish to have charges laid, the case was classified as unfounded. Mr. Griffiths noted, "The refusal of women to proceed with the laying of charges does not indicate that a sexual assault did not take place."<sup>257</sup>
7. Women identified concerns about frequent changes in the investigating officers and the lack of information provided to victims about the process. There were also serious concerns regarding the attitudes of officers towards sex trade workers, women of colour, women experiencing homelessness, women whose first language is not English, and women with physical disabilities and mental health issues.
8. Despite significant investments in information systems, there was still no major case management computer and information system, underuse of technology that would recognize links between crimes to converge investigation onto the same target, and no effective system to identify training requirements and track officers' attendance at training. A major case management system was being piloted at the time of the Auditor's Report, in response to the Campbell Report (summarized above in section 3.3.). Griffiths noted that the ViCLAS system (Violent Crime Linkage Analysis System) is a province-wide system that "takes an inordinate amount of time to identify linkages."<sup>258</sup>
9. Police training on the investigation of sexual assaults was a major theme of the Report. Experienced divisional investigators generally received a ten-day course, "Sexual Assault and Child Abuse" (SACA). There was capacity to train 72 officers per year. However, there was no central database to identify whether a particular officer handling sexual assaults had taken training. Officers were selected to take the course based on their availability rather than on deployment requirements, suitability, or interest in sexual assault investigations. There was no program in place to provide updated training to those who had taken SACA. The SACA course mostly consisted of lectures given by experienced officers, was fairly elementary, and did not allocate the appropriate amount of time to specific topics. There was also duplication of content with other courses, and training was decentralized. Frontline officers, who are typically the first officers women who have been assaulted will meet, did not have sufficient training on these investigations. Sexual Assault Squad members had separate training through attendance at conferences, seminars, and workshops. There was no structured training program, no identification of specific training needs, and no evaluation of the effectiveness of the training. There were also issues with the usefulness of the annual Sexual Assault Investigators Conference organized by members of the Sexual Assault Squad. In general, police training was done by police officers, who were not experts in adult education and not always selected for their expertise.
10. Following the Campbell Report, which concluded that Mr. Bernardo would have been apprehended much sooner if ViCLAS had been in place and subject to mandatory reporting, police regulations were amended to require that all investigations meeting certain criteria be

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<sup>257</sup> "Review of the Investigation of Sexual Assaults: TPS," p. 55.

<sup>258</sup> "Review of the Investigation of Sexual Assaults: TPS," p. 64.

submitted to ViCLAS.<sup>259</sup> Officers were still failing to comply with ViCLAS reporting requirements. There was resistance due to the time required to submit the reports.

11. The relationships between police and most community agencies serving women who have been sexually assaulted were poor, lacking trust, cooperation, and coordination. Improvements in those relationships would increase reporting rates and improve the investigation of sexual assaults.
12. It was “particularly disconcerting” that many of the concerns identified in the audit and in the Jane Doe decision had been raised in a 1975 Report of the Police Committee on Rape.<sup>260</sup>
13. Despite the outcome of the Jane Doe case, there was “still no written protocol establishing the circumstances in which police should issue a warning that a sexual predator is active in the community.”<sup>261</sup> Police had issued a warning in a recent serial predator case in Scarborough, but were criticized for creating fear and panic without providing the information necessary for women to protect themselves.<sup>262</sup>
14. Mr. Griffiths also reviewed the recommendations of the Campbell Report (see above at 3.3) and noted the status of those recommendations. He noted that the police force had information management software specifically for investigations. Training in case management appeared to have been implemented, but other training recommendations had not.

Mr. Griffiths conducted two follow-up reviews of the implementation of his recommendations, and summarized them in a 2010 report.<sup>263</sup> He found that the Toronto Police Service had made significant improvements in its sexual assault investigations in the ten-year period following his initial audit.

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<sup>259</sup> On p. 84 of “Review of the Investigation of Sexual Assaults: TPS,” the Auditor described ViCLAS as follows:

ViCLAS is a national computer database program designed and operated by the RCMP for the collection of information on:

- i. all solved or unsolved homicides and attempted homicides;
- ii. solved or unsolved sexual assaults;
- iii. missing persons, where the circumstances indicate a strong possibility of foul play and the victim is still missing;
- iv. unidentified bodies, where the manner of death is known or suspected to be homicide; and
- v. all non-parental abductions and attempted abductions.
- vii. The system’s objectives are:
  - viii. the creation of a database for the collection of data on all homicides, sexual offences, abductions, and all related attempts;
  - ix. the comparison of cases leading to the identification of serial rapes and murders;
  - x. the monitoring of missing persons and the providing of potential identities for found human remains; and
  - xi. the examination of reported false allegation cases to identify any serial reports of this nature, or to identify reports which are believed to be false but are in fact genuine complaints.

<sup>260</sup> “Review of the Investigation of Sexual Assaults: TPS,” p. 106. According to Justice MacFarlane’s reasons for judgment, this 1975 report was written by four members of the Metropolitan Toronto Police Force for its Chief in response to a Brief prepared by the Rape Crisis Centre. The report raised questions about the high number of sexual assault reports which were determined to be “unconfirmed,” and suggested that failure to properly investigate and officer bias may play a role. It also noted significant concerns about the treatment of victims by investigators.

<sup>261</sup> “Review of the Investigation of Sexual Assaults: TPS,” p. 106.

<sup>262</sup> Mr. Griffiths did not provide details of this case, but media reports suggest it may have been the “Scarborough bedroom rapist”: see “Arrest made in Toronto’s bedroom rapist case,” Canadian Broadcasting Corporation, September 27, 1999, <https://www.cbc.ca/news/canada/arrest-made-in-toronto-s-bedroom-rapist-case-1.196560>

<sup>263</sup> “The Review of the Investigation of Sexual Assaults – A Decade Later.” Toronto Police Service, 2010, <https://www.toronto.ca/legdocs/mmis/2010/cc/bgrd/backgroundfile-33266.pdf>

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 1) City Council forward this report to the Toronto Police Services Board. The Chief of Police be requested to provide a written response within six months to the Police Services Board with regard to the recommendations contained in this report. The report prepared by the Chief of Police include a specific workplan and timetable for the implementation of the recommendations.
2. (Recommendation 2) The Chief of Police appoint a senior officer to assume responsibility and be accountable for the implementation of the recommendations. This officer should be familiar with the conduct of sexual assault investigations and preferably have served in an investigative or policy role in this area.
3. (Recommendation 3) A regular, structured reporting process to the Police Services Board be initiated in regard to the implementation of the recommendations. Reports should be prepared for submission to the Board on a quarterly basis.
4. (Recommendation 4) The City Auditor be requested to conduct a follow-up audit in regard to the status of the recommendations contained in this report, the timing of such audit to be consistent with the timeframe outlined in the report of the Chief of Police. The City Auditor be required to report directly to the Toronto Police Services Board in regard to the results of the follow-up audit.
5. (Recommendation 6) The Chief of Police conduct an evaluation of the additional staffing requirements of the Sexual Assault Squad. Staff resources in relation to the increase in responsibilities of the squad be redeployed from other areas within the service.
6. (Recommendation 8) The recruitment of staff to the Sexual Assault Squad be restricted to staff who are trained and experienced in the investigation of sexual assaults and have demonstrated an interest and an aptitude in the investigation of such cases. Potential candidates to the squad be evaluated against the core competencies required for positions in the squad.
7. (Recommendation 11) The Sexual Assault Squad give consideration to the establishment of a Sexual Assault Hotline. The establishment of such a hotline be set up after consultations with key stakeholders who work in the area of sexual assault. The availability of such a hotline be widely communicated to women in the community.
8. (Recommendation 12) The Chief of Police direct all first-response officers immediately that policies and procedures be complied with. First officers responding to sexual assault incidents be specifically directed that they collect only basic information concerning the assault from the woman who has been sexually assaulted. The extent of what constitutes “basic information” should be clearly articulated in the form of a detailed interview checklist. The Sexual Assault Squad be required to develop a detailed interview checklist in order to assist officers during the initial interview. Only officers with specific training in sexual assault investigations be allowed to conduct detailed interviews with women who have been sexually assaulted. The Sexual Assault Squad be charged with the responsibility of ensuring that directives are complied with.
9. (Recommendation 13) The Chief of Police immediately direct all officers in charge that policies and procedures be complied with. Existing policies require that officers in charge are required to attend the scene of a sexual assault in order to ensure that the preliminary investigation is conducted appropriately. The Sexual Assault Squad be charged with the responsibility of ensuring that directives are complied with.

10. (Recommendation 16) All occurrence reports relating to sexual assault be reviewed by supervisory staff at the divisional level prior to submission to the Sexual Assault Squad. Evidence of the review be appropriately documented. Incomplete or inappropriate occurrence reports be discussed with the officer concerned and changes made where necessary. Continued problems relating to the preparation of occurrence reports be dealt with through training and finally, if necessary, discipline. Occurrence reports prepared by members of the Sexual Assault Squad be reviewed and approved by supervisory staff.
11. (Recommendation 17) Any concerns identified during the review of occurrence reports by the Sexual Assault Squad be communicated to the officer who approved the report. Inappropriate or incomplete reports be returned to the originator for resubmission. Continued problems relating to the preparation of occurrence reports be dealt with through training and finally, if necessary, discipline.
12. (Recommendation 18) Under no circumstances should a first-response officer make a determination as to whether a sexual assault incident is classified as unfounded. The determination of this matter be reviewed and approved by a qualified trained sexual assault investigator. All occurrence reports contain information sufficient to substantiate conclusions.
13. (Recommendation 19) The definition of what constitutes an unfounded sexual assault occurrence be reviewed. Incidents in which a woman decides not to proceed with the laying of charges should not be automatically classified as unfounded.
14. (Recommendation 25) The Sexual Assault Squad evaluate its management information needs in consultation with the Information and Technology Divisions of both the Toronto Police Service and the City of Toronto. These needs be addressed through the budget process on a priority basis.
15. (Recommendation 26) The Chief of Police ensure that the comprehensive internal review of training currently underway take into consideration the recommendations contained in this report.
16. (Recommendation 28) The Sexual Assault Squad be required to maintain an accurate up-to-date listing of police officers who have received sexual assault training. This listing also contain information concerning the date of attendance. This information be used as a basis to:
  - a. ensure compliance with police directives that only those police officers who have received sexual assault training be allowed to conduct sexual assault investigations;
  - b. forecast training needs throughout the service; and
  - c. appropriately deploy police officers to those areas where the need is the greatest.
17. (Recommendation 29) The Sexual Assault Squad be required to conduct a long-term analysis in regard to the projected requirements for police officers trained in the investigation of sexual assaults. This analysis take into account potential retirees over the next number of years as well as the anticipated demands for such trained officers. This analysis be used to determine the adequacy or otherwise of the current training schedule and, where appropriate, the training schedule be amended.
18. (Recommendation 30) The Sexual Assault Squad assume responsibility for the development of training activities relating to the investigation of sexual assaults. In addition, the squad assume responsibility for the coordination of all such training throughout the service.
19. (Recommendation 31) A re-evaluation of the content of the Sexual Assault and Child Abuse (SACA) course be undertaken. Particular emphasis be placed on course content and its

relevance to practical day-to-day experiences. Course content not directly relevant to the work of divisional sexual assault investigations be eliminated. The course be designed in a structured, methodical manner. Community input be sought in the restructuring of the course content.

20. (Recommendation 32) The process by which officers are selected to attend sexual assault and child abuse training be formalized. Supervisors be held accountable for the selection of appropriate course attendees.
21. (Recommendation 33) As a part of the evaluation of the SACA course, consideration be given to incorporating certain components of the SACA course into the training programs provided to recruits and first-response officers.
22. (Recommendation 34) Training provided to recruits and frontline officers in relation to the investigation of sexual assaults be re-evaluated. In addition, an evaluation of the RCMP publication, "An Investigative Guide to Sexual Assaults" be conducted by senior staff at CO Bick College [the police training facility] in conjunction with members of the Sexual Assault Squad and the community. A determination should be made as to whether or not this particular document would be useful in the training of police officers.
23. (Recommendation 35) An evaluation be conducted by the Sexual Assault Squad in relation to the need for an ongoing update training process in regard to police officers who have previously attended the SACA course.
24. (Recommendation 36) An evaluation of all training courses and conferences attended by members of the Sexual Assault Squad be conducted. Individual squad members be required to document their training requirements and align such requirements with the objectives of the squad. These requirements be reviewed by the staff inspector for approval. In order to minimize duplication and to reduce costs, attendance at courses and conferences be coordinated with other members of the squad. Attendance at courses and conferences that have no relevance to the professional development requirements of the squad should not be approved.
25. (Recommendation 37) An evaluation of the Sexual Assault Investigators Conference be conducted to determine its effectiveness, relevance, and costs.
26. (Recommendation 40) Consideration be given to the use of external community resources in the training of sexual assault investigators. External community resources be compensated for their work.
27. (Recommendation 41) The recruitment and appointment of trainers to CO Bick College be formalized. The skills and qualifications necessary to become a trainer be explicitly identified and used in the appointment of all training staff.
28. (Recommendation 44) Violent Crime Linkage Analysis System (ViCLAS) reports must be completed and submitted to the Toronto Police Service Sexual Assault Squad coordinator within the prescribed time limit (21 days) as demanded in the Toronto Police Service Directive 05-19, Violent Crime Linkage Analysis System.
29. (Recommendation 45) ViCLAS reports must be completed and submitted to the Ontario Provincial Police ViCLAS Centre in Orillia by the Toronto Police Service Sexual Assault Squad within the prescribed time limit (a further nine days) as required by Ontario Regulation 550/96 of the Police Services Act.
30. (Recommendation 46) All police officers be informed of the reporting requirements of ViCLAS.

31. (Recommendation 47) A regular reporting process be initiated in regard to ViCLAS submissions. All instances of noncompliance with the regulation and Directive 05-19 should be reported immediately to the appropriate Deputy Chief of Police for action.
32. (Recommendation 48) All ViCLAS reports reviewed by the Sexual Assault Squad include evidence of such review. In addition, any deficiencies noted during this review should be communicated to the originator of the report as well as to the division. Such a process would reduce future deficiencies and accelerate the submission of reports to Orillia.
33. (Recommendation 56) The Sexual Assault Squad be required to form relationships with community groups, share information and concerns and work together to meet common objectives. In addition, consideration be given to the establishment of a formal succession planning process in order to ensure that the transfer of police officers to other responsibilities does not disrupt relationships with community organizations.
34. (Recommendation 57) The Chief of Police develop a written protocol detailing the circumstances in which a general warning should be given to the public that a suspected serial sexual predator is active. Community consultations should take a place in the preparation of this directive.

#### 4.2. The Ipperwash Inquiry (Ontario, 2007)<sup>264</sup>

In 1995, an officer with the Ontario Provincial Police (OPP) shot and killed Dudley George, whose family was from the Stony Point Reserve, during a protest by Stony Point and Kettle Point First Nations members and their supporters at Ipperwash Provincial Park. The park and surrounding land had been the territory of the Kettle Point and Stony Point First Nations, and the Park lands held an Indigenous burial ground. A significant portion of the territory had been appropriated by the federal government decades before, requiring the forcible relocation of the community to a much smaller and inferior area; that land was never returned, despite repeated commitments by the federal government to do so. The burial ground was not protected and had been desecrated. Two days before the shooting, Stony Point and Kettle Point members, descendants, and supporters occupied the Park as part of a protest to demand the return of their territory and in order to protect the burial grounds. The OPP advanced on the protesters and severely beat one of them; they then shot a teenage protester who was driving a bus through the crowd. The boy survived. An OPP officer then shot and killed Dudley George. The officer claimed that Mr. George had been holding a rifle; in fact, Mr. George was unarmed. The officer who shot Mr. George was eventually convicted of criminal negligence causing death.

The judicial commission of inquiry was held several years later, after a change in Government. The Commissioner, Justice Sidney Linden, concluded that the OPP had no reason to advance on the protesters; that there were serious failings in OPP intelligence leading them to rely on false reports and rumours, which greatly exaggerated the apparent danger of the protest; that the incident commander had been told that the Government wanted the protesters to be removed and improperly conveyed that view to other OPP members; that the Premier of Ontario at the time, Mike Harris, had shouted "I want the fucking Indians out of the park!" at a meeting of senior officials about the protest; that OPP members made numerous racist and aggressive comments to protesters; that there was a serious failure to consider and use peaceful efforts to manage the

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<sup>264</sup> "Report of the Ipperwash Inquiry," Submitted in 4 volumes to the Ministry of the Attorney General of Ontario (May 2007), <https://www.attorneygeneral.jus.gov.on.ca/inquiries/ipperwash/report/index.html>.

situation, including negotiation; and that there was a serious failure on the part of the OPP, the media, the community, and government officials to understand and appreciate the history of the Indigenous people, their claims to the land, and the significance of the park as the site of a burial ground. Justice Linden noted the large number of previous inquiries that had attempted to address anti-Indigenous racism and bias in policing. He also noted that although the Canadian Association of Chiefs of Police and the RCMP had both adopted policies of “bias-free policing”, and the OPP and province had taken significant steps to address Indigenous–police relations since the events at Ipperwash, nonetheless, “the Inquiry heard consistent criticisms pointing to biased or racist policing.”<sup>265</sup>

The Government of Ontario’s website states that most of the recommendations have been implemented or are in the process of being implemented.<sup>266</sup>

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 36) The provincial government and Ministry of Aboriginal Affairs should create mechanisms for obtaining input from Aboriginal communities on planning, policy, legislation, and programs affecting Aboriginal interests.
2. (Recommendation 37) The provincial government should establish and fund an Ontario Aboriginal Reconciliation Fund. The Ministry of Aboriginal Affairs should work with First Nations and Aboriginal Organizations to determine the mandate, governance structure, funding guidelines, and administrative structure of the fund. The provincial government should commit sufficient resources to the fund to enable it to achieve its objectives.
3. (Recommendation 38) Police services in Ontario should promote peacekeeping by adopting the following objectives when policing Aboriginal occupations and protests:
  - a. minimize the risk of violence at occupations and protests;
  - b. preserve and restore public order;
  - c. facilitate the exercise of constitutionally protected rights;
  - d. remain neutral as to the underlying grievance; and
  - e. facilitate the building of trusting relationships that will assist the parties to resolve the dispute constructively.
4. (Recommendation 39) The OPP should maintain its Framework for Police Preparedness for Aboriginal Critical Incidents, Aboriginal Relations Teams, and related initiatives as a high priority and devote a commensurate level of resources and executive support to them.
5. (Recommendation 40) The OPP should commission independent, third-party evaluations of its Framework for Police Preparedness for Aboriginal Critical Incidents and Aboriginal Relations Team program. These evaluations should include significant and meaningful participation for Aboriginal representatives in their design, oversight, and analysis.
6. (Recommendation 41) The OPP should post all significant OPP and provincial government documents and policies regarding the policing of Aboriginal occupations and protests on the OPP website. The OPP should also prepare and distribute an annual report on the Framework for Police Preparedness for Aboriginal Critical Incidents.
7. (Recommendation 42) The OPP should establish a formal consultation committee with major Aboriginal organizations in Ontario.

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<sup>265</sup> “Report of the Ipperwash Inquiry,” p. 274.

<sup>266</sup> <https://www.ontario.ca/page/ipperwash-inquiry-report>

8. (Recommendation 46) The provincial government should commit sufficient resources to the OPP to support its initiatives for policing Aboriginal occupations. This funding should be dependent upon the OPP agreeing to commission and publish independent evaluations of the Framework for Police Preparedness for Aboriginal Critical Incidents and the Aboriginal Relations Team program.
9. (Recommendation 64) The OPP should develop active, ongoing monitoring strategies for its police–Aboriginal relations strategy and programs, including:
  - a. commissioning an independent, third-party evaluation of its Native Awareness Training and recruitment initiatives;
  - b. commissioning data collection studies to evaluate police decision-making and operations. These studies should be designed in partnership with First Nation organizations and the Ontario Provincial Police Association, if possible. And
  - c. working with First Nations organizations to develop a more formal monitoring and implementation program for the OPP police/Aboriginal programs.
10. (Recommendation 65) The provincial government should develop a provincial police–Aboriginal relations strategy. This strategy should publicly confirm the commitment by the province to improving police–Aboriginal relations in Ontario. Elements of this strategy should include the following:
  - a. The Ministry of Community Safety and Correctional Services should work with the OPP and Aboriginal organizations to develop a provincial policy supporting the OPP police–Aboriginal relations programs.
  - b. The Ministry of Community Safety and Correctional Services should develop a provincial research and data collection strategy to promote improved police–Aboriginal relations policy and programs and bias-free policing across Ontario.
  - c. The Ministry of Community Safety and Correctional Services should issue a guideline for police forces in Ontario promoting best practices in police–Aboriginal relations.
  - d. The Ministry of Natural Resources (MNR) should develop and implement a dedicated MNR–Aboriginal relations strategy, consistent with the analysis and recommendations in this Report.
11. (Recommendation 66) The provincial government should commit sufficient resources to the OPP to support its police–Aboriginal relations initiatives. This funding should be dependent upon agreement by the OPP to commission and publish independent evaluations of its Native Awareness Training and recruitment initiatives.

## 5. ACTIVE SHOOTER INCIDENTS<sup>267</sup>

### 5.1. Public Fatality Inquiry into the Deaths of James Wilbert Galloway and Martin Charles Ostopovich (“Galloway Inquiry”) (Alberta, 2006)<sup>268</sup>

On February 28, 2004, a man in Spruce Grove, Alberta shot and killed Constable James Galloway, a police officer. The shooter, Martin Ostopovich, was then killed by police. Judge Ayotte of the Alberta Provincial Court conducted a public fatality inquiry into the two deaths.

Police had been called to the scene after Mr. Ostopovich had apparently shot a bullet into a neighbour’s car. Mr. Ostopovich’s wife told police not to come into the home. She said her husband, who was in the home, was hearing voices telling him to kill someone and that he hated police. He had been diagnosed as paranoid delusional and was not taking his medication. He also had two high-powered rifles in the home. Police moved Ms. Ostopovich to a safe location and set up a perimeter around the house. Mr. Ostopovich called a radio station and said someone was going to die that day. Sgt. Koersvelt, the senior officer on duty, directed officers to call the other residents of the cul-de-sac and tell them to stay in their basements until the situation was resolved. He also ordered traffic blocked off in the area. He spoke with Mr. Ostopovich on the phone, who said he would “take out” the next person he saw. Sgt. Koersvelt then called for an Emergency Response Team (ERT). He called Mr. Ostopovich again and spoke to him for almost half an hour. Mr. Ostopovich was very agitated, irrational, and threatening during this phone call.

The ERT team arrived at approximately 4:00 PM and took over the operation. They had difficulty finding places to station because Mr. Ostopovich’s home was on a cul-de-sac, very close to the neighbouring homes, and from his kitchen, he could see everything happening in front of his home. An assault team of officers was stationed to the far side of each of the neighbouring houses. Neither team could see the front of the residence, so they had to depend on radio transmissions to know what was happening. Snipers were placed on each side of the house, and a third sniper was placed on the roof of the home behind Mr. Ostopovich, where he could see Mr. Ostopovich if he left his home. The snipers relayed information to the other officers.

Mr. Ostopovich left his house at one point, retrieved a CD from his truck, and returned to the house before either of the assault teams could react. The truck was very close to the door. Cst. Pearson, the ERT team leader, was concerned that Mr. Ostopovich could get into his truck and begin driving before they would be able to stop him. He decided against having a sniper shoot the truck’s tires because the officers would not be able to hit the front tires and the truck would not be fully disabled. They could not shoot out the engine block because the only weapon with the capacity to do that was being repaired. They did not want to drive other vehicles in to block the truck, as Mr. Ostopovich would be able to shoot the drivers and it might provoke him. Cst. Pearson decided on a plan whereby, in the event that Mr. Ostopovich tried to get into his truck, the ERT dog handler, Cpl. Galloway, would drive his vehicle toward the truck and ram it. Cpl.

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<sup>267</sup> There was a coroner’s inquest into the deaths of the fourteen women killed at the École Polytechnique, along with the death of the perpetrator. That inquest made findings of fact and raised questions regarding the response to the shootings, but did not make recommendations; it has therefore not been included here. The Report of the Coroner’s Investigation Concerning the Massacre at l’École polytechnique de l’Université de Montréal (1991) is available here: [https://www.diarmani.com/Montreal\\_Coroners\\_Report.pdf](https://www.diarmani.com/Montreal_Coroners_Report.pdf)

<sup>268</sup> “Report to the Minister of Justice and Attorney General: Public Fatality Inquiry into the Deaths of James Wilbert Galloway and Martin Charles Ostopovich” (“Report of the Galloway Inquiry”). Province of Alberta (November 2006), <https://open.alberta.ca/dataset/ffde0b3d-b1fa-4a17-984d-b1395af104b6/resource/b2224163-8910-4ad8-a381-bd8eede7b03c/download/01132-report-to-minister-into-death-of-james-wilbert-galloway-and-martin-charles-ostopovich.pdf>.

Galloway's vehicle was close to the house and had a winch on the front, which would enhance its ramming capacity. Normally a sniper would drive a take-down vehicle, but the snipers were required to maintain their positions so they could inform the others of Mr. Ostopovich's movements. Cpl. Galloway, who was a veteran of ERT operations, insisted on driving his vehicle himself. Another officer, Cst. Taniguchi, was to accompany him as his cover man. They were both instructed to leave the vehicle immediately after ramming Mr. Ostopovich's car and to move behind it for protection. The intention was for Cpl. Galloway to T-bone the truck in order to stun Mr. Ostopovich, if possible. The ERT members had only limited training on ramming vehicles, and none of them had ever tried to ram a vehicle in this fashion.

While this plan was being discussed, the ERT negotiator had two long telephone conversations with Mr. Ostopovich. Mr. Ostopovich said he would go to the Spruce Grove detachment and shoot it out with police and referred to "suicide by cop." The negotiator believed Mr. Ostopovich was high risk, meaning he would be unlikely to come back to equilibrium because his stressors had exceeded his capacity to cope with them.

The officers discussed whether to inform Mr. Ostopovich that the ERT team was on site. They decided to tell him, because he might learn about it himself from the news, which would destroy whatever rapport Mr. Ostopovich had with the negotiator. The officers also hoped that Mr. Ostopovich might surrender peacefully if he learned that the ERT team was there. They were aware that this knowledge might instead prompt him to confront the police. The negotiator called Mr. Ostopovich and told him the ERT team was present. Mr. Ostopovich hung up and left the house with rifles in each hand. He went to his truck and got in and started backing down his driveway. Cpl. Galloway rammed the truck, which wedged the truck against two other vehicles parked nearby. This was not anticipated. Cst. Taniguchi opened the passenger door, saw Mr. Ostopovich leveling his rifle at him, and crouched under the console. Cst. Taniguchi fired one or two shots through the windshield. Cpl. Galloway got out of the driver's seat and moved toward the rear of the vehicle. Mr. Ostopovich shot him in the back as he was repositioning, and he died almost instantly. The other officers immediately began shooting at Mr. Ostopovich, and he died in hospital later that day.

Two years prior to the events, Mr. Ostopovich made threats against RCMP officers. For that and other reasons, he had been brought to the psychiatric unit of a hospital per the Mental Health Act. His assigned psychiatrist, Dr. Sandy Frank, found him to be aggressive and intimidating, and he refused to follow the rules on the unit. He was diagnosed as paranoid delusional. Dr. Frank discharged him after two weeks, against medical advice, because under the Mental Health Act, he could only be detained while he presented an imminent likely danger to himself or others.

The participants at the inquiry raised concerns about the decision to tell Mr. Ostopovich about the ERT team without consulting with mental health specialists or his wife; about the decision to have Cpl. Galloway, who was not a member of the assault team, drive the ramming vehicle; about the decision to have Cpl. Galloway and Cst. Taniguchi leave the vehicle after the ramming; and about the role of snipers and when lethal force is justified during a police stand-off.

Judge Ayotte said:

I intend to make no comment on those decisions, other than to say that credible reasons were given for the choices which were made. Every incident in which an ERT team is involved is unique. Team members, whether they be incident commanders, team leaders, snipers or assaulters, are routinely called upon to make quick decisions, often with incomplete information about the person or persons with whom they are dealing. Given those realities, it would be inadvisable to hamper their work with a long list of guidelines

restricting acceptable responses in every situation. ERT teams are elite units in the sense that they are specially trained and specially equipped to respond to situations beyond the resources of standard police forces. Their effectiveness will always depend on the application of their intelligence and training to any given situation. If they are unduly shackled with policies that neutralize their ability to adjust to the almost limitless scenarios they will face, we run the real risk that they will be ineffective when a flexible response may be what is required to achieve the result we want.

I understand that the approach I describe will mean tragic consequences in some circumstances, but it will also mean the successful resolution of some crises that would otherwise end badly. When tragedies do occur, it would be a mistake to assume that the blame must inevitably fall on those who had the greatest resources. There are at least two players in police stand-offs, and one of them is, almost by definition, unpredictable. That was the case here. Given the abundant evidence of Mr. Ostopovich's apparent determination, as a result of his mental illness, to confront police and bring about his own death, there was nothing in what I heard to suggest that a less tragic result would necessarily have been achieved if different decisions had been made.<sup>269</sup>

The sniper on the roof, Cpl. Christianson, testified that he understood his primary role to be to observe and to communicate his observations to the other members of the team. Judge Ayotte said this was appropriate, given that he was the only member of the ERT team able to see what Mr. Ostopovich was doing. He found that Cpl. Christianson was well aware of his role as a sniper and was prepared to use lethal force if necessary. Cpl. Christianson said he did not shoot Mr. Ostopovich when he left the house because society would not condone him shooting him in the back in that situation. Judge Ayotte noted that Cpl. Christianson and all the ERT members showed clear dedication to resolving incidents like this one without loss of life. He rejected calls from inquiry participants to recommend changes to the use of force policies and training, primarily to allow snipers to shoot when the opportunity arises, as "ill-founded and contrary to society's tradition of respect for every human life."<sup>270</sup>

At the time of the fatality inquiry, there were three part-time ERT teams in Alberta. Each team was required to have twelve officers, but two had only eleven at the time. ERT members all had full-time police duties in addition to their ERT duties and were called away when ERT requests were made or when they were required to attend training. That in turn reduced the numbers of local regular duty officers on shift. This made it unrealistic to expect ERT members to attend significantly more scenario training. It was also difficult to staff the teams, given the RCMP practice of transferring members in and out of communities where ERT teams were based and given the high qualifying standards they had to meet. The part-time model also created hardship for the team leaders and seconds-in-command, who had significant administrative duties. ERT members were considered "support positions" rather than local staff, and it was therefore difficult to get government support for funding new, full-time positions. Full-time ERT members would also have more difficulty with career advancement than regular members do. However, despite these difficulties, Judge Ayotte recommended that the RCMP should move toward full-time ERT teams. He also concluded that despite the difficulties already encountered in staffing the teams, the teams should be larger to avoid having to call on members who have just completed shifts. This echoed the recommendation of the internal RCMP Tactical Review of the incident. These larger teams could include both full- and part-time members.

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<sup>269</sup> "Report of the Galloway Inquiry," p. 7.

<sup>270</sup> "Report of the Galloway Inquiry," p. 8.

Judge Ayotte considered the many contexts in which ERT teams are called upon. He said there are increasing challenges confronting the effective use of ERT teams without a concurrent loss of life, and the frequency with which ERT teams are called on is likely to increase in the future, and those calls may include attempted terrorist activities. He said,

Whether we like it or not, we live in an age of rapid technological advancement where those so inclined have, despite our best efforts, increasing access to more sophisticated and powerful weaponry. We can expect then that ERT teams will be confronted with predictably more complicated and dangerous incidents requiring a high level of skill and training and equipment which matches, or ideally exceeds, the resources available to those they are asked to control.<sup>271</sup>

Judge Ayotte noted that making ERT teams full-time would give them more time for training but acknowledged that changes were required to increase training time in the interim. The two days per month of training the ERT members received was not sufficient, given the broad range of skills they must acquire and maintain. He noted that the tactical teams of the Edmonton Police Service, the municipal equivalent of the RCMP's ERT teams, were full-time and spent almost a quarter of their time in training. He also noted that one of the three Alberta ERT teams was required to respond to incidents in most of the northern part of the province "and accordingly must deal with both rural and urban incidents, the approach to which presents different types of problems and involves the implementation of diverse responses often requiring specialized skills and tactical maneuvers."<sup>272</sup>

Judge Ayotte heard evidence that the training provided to the negotiators on dealing with people with mental health issues was cursory. In contrast, extensive training was provided to officers assigned to the Edmonton municipal Police and Crisis Teams (PACT), which respond to mental health emergencies.

Neither Cst. Galloway nor Mr. Ostopovich would have survived with the assistance of emergency medical services. However, Judge Ayotte found that medical resources at ERT incidents could prevent deaths in other cases. Smaller communities would be unlikely to have emergency medical services available during crises. Judge Ayotte therefore encouraged a local initiative to have paramedics accompany ERT teams on call-outs.

Judge Ayotte noted that a number of concerns about equipment raised by this incident had been or were being addressed by the time of his inquiry. Ceramic body armour was expected to replace protective vests, which were not able to stop a high-powered rifle shot. A new and improved mobile command centre was set to be provided to the three Alberta ERT teams. The RCMP was purchasing more sophisticated night vision equipment. However, he said, "in an age of ever-changing innovation and advances in weaponry, it is important that ERT teams be kept constantly supplied with up-to-date equipment."<sup>273</sup> He recommended an annual review by RCMP management to ensure that the ERT continue to be properly equipped. He also recommended the purchase of at least one armoured vehicle in Alberta to be available to ERT teams, provided the cost could be managed.

Judge Ayotte concluded that the incident might have been avoided had Mr. Ostopovich received the treatment he required for his mental illness. A trained psychiatrist from Edmonton testified that

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<sup>271</sup> "Report of the Galloway Inquiry," p. 9.

<sup>272</sup> "Report of the Galloway Inquiry," p. 11.

<sup>273</sup> "Report of the Galloway Inquiry," p. ##.

34% of those living in the area met the criteria for mental illness, and half of those would have a major emotional event at some point in their lives. The suicide rate for young men had quadrupled in the previous 25 years. The pressure on the mental health resources in Alberta was significant and increasing, but the province faced challenges attracting people to the practice of psychiatry and retaining them once they were trained.

Judge Ayotte also praised the Police and Crisis Teams (PACT) system implemented by the Edmonton Police Service. There were three teams in the city, each consisting of a mental health therapist and a police officer trained in mental health issues. The teams were available 24 hours per day. The teams had proven adept at persuading people to obtain treatment voluntarily and were able to exercise legislative powers of involuntary committal where necessary. However, the PACT teams were not available outside the city, and there were concerns that the likely volume of calls would not justify the creation of teams in suburban areas. Judge Ayotte noted that alternatives to full-time teams in these areas could include having part-time teams on call (similar to the existing ERT system) or having all RCMP officers in suburban areas receive mental health training. He said, "Aside from the obvious public benefit from the availability of such a resource, there is a wider public interest in ensuring that every police officer is familiar with and sensitive to mental health issues."<sup>274</sup>

The evidence of a lack of communication between the mental health system and family physicians was troubling to Judge Ayotte. Mental health treatment providers were not permitted to inform family physicians of their patients' mental health issues or treatment without the patients' consent. Judge Ayotte disagreed with that interpretation of patients' privacy rights, saying,

...[T]here should be some attempt to foster co-operation between health care professionals in an effort to monitor potential problems. I see nothing affecting in any substantial way a patient's right to privacy by requiring one medical doctor to notify another of an assessment and recommended course of treatment for the latter's patient, especially since both physicians have the same obligation of confidentiality to that patient. The patient still has the right not to continue treatment and to refuse to attend his [or her] doctor's office, but it would at least give family members, friends and the public-at-large some comfort to know that the physician most likely to be in regular contact with that person has a complete knowledge of his or her mental history and may thus be better able to give cogent advice on what steps to take when problems arise.<sup>275</sup>

Judge Ayotte also commented on the role of potential media reports on Cst. Pearson's tactical decision to inform Mr. Ostopovich about the presence of the ERT team. He suggested that there be dialogue between the RCMP and media representatives to find ways to ensure that the public is provided with appropriate information without compromising the public interest in achieving a safe resolution to crises such as the incident giving rise to the fatality inquiry.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission:**

1. I therefore respectfully recommend that as a first step to the eventual formation of full-time teams, two full-time positions per team be created, being team leader and second-in-command, to be primarily responsible for the recruitment of prospective team members and the arrangement and provision of ongoing team training in addition to their regular duties as team members. I further recommend that, in consultation with RCMP management, attempts

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<sup>274</sup> "Report of the Galloway Inquiry," p. 16.

<sup>275</sup> "Report of the Galloway Inquiry," p. 21.

be made to enhance the career development opportunities of those positions as a means of attracting high quality candidates.

2. I therefore recommend, notwithstanding the difficulties involved, that part-time ERT teams be gradually increased to twenty members. To maintain continuity, it is also recommended, so far as reasonably possible, that the transfer of ERT team members be confined primarily to areas in close enough proximity to their present posting to enable them to maintain their ERT team duties or to areas which would enable them to serve with one of the other provincial ERT teams, thus ensuring a maximum return on the time and expense involved in their training. While I understand that the question of promotion presents special difficulties, efforts should be made to give some priority to ERT team candidates who are otherwise qualified when promotion opportunities become available in the areas where they are presently posted or where other ERT teams are based. Finally, I make it clear that the numbers I recommend do not include specialized support staff such as dog handlers, negotiators, and communications personnel.
3. I therefore respectfully recommend that training time for ERT teams be increased initially to three days per month and that policymakers be prepared, after a review with the teams themselves of the impact of that change, to increase the time allotted to four days per month if warranted. I also recommend that annual "cross-training" with the Edmonton Police Service Tactical Units be pursued and that any additional funding and training time which may be required be provided. I further recommend that dog handlers, being intimately involved at the front line in most incidents, be required to attend all ERT team training sessions and that other support personnel such as communications people and negotiators participate in training sessions where their involvement is deemed important to the achievement of the specific goals of that particular session. Finally, I recommend that incident commanders be required to participate in sufficient training sessions to enable them to work with and become familiar with team members and the level of skill they possess and to enable team members to become familiar with their commanders and the duties they are required to discharge.
4. I therefore respectfully recommend that negotiators assigned to Alberta ERT Teams be provided at a minimum with the same mental health training now provided to PACT team police officers in the City of Edmonton.
5. I therefore respectfully recommend that, if necessary, extra funding be made available to enable a contracted paramedic to be added as a support person to every ERT team and that he or she be provided with the funding and time to train with that team.
6. I therefore respectfully recommend that there be an annual review conducted by RCMP management to ensure that ERT equipment is keeping pace with what has become available on the street and that government be prepared to provide extra funding, if required, to purchase any upgraded equipment which might become necessary to achieve that goal.
7. I therefore respectfully recommend that if non-budgetary issues do not preclude such a purchase, that at least one armoured vehicle be acquired and kept at a central location so that it could be transported upon request to any of the Alberta ERT teams. Given the geographical realities of the province, the need for maintenance and the possible difficulties involved in transporting such a vehicle over longer distances, it would be ideal, funds permitting, if two such vehicles could be purchased.
8. I therefore respectfully recommend that the Government of Alberta promote, in consultation with Health Canada, the creation of part-time PACT teams in the suburban areas surrounding the City of Edmonton, which promotion should include, if necessary, the financial support of the province. It is further respectfully recommended that funding be provided for ongoing

monthly mental health education for all RCMP officers stationed in the suburban Edmonton area. It is finally respectfully recommended that the Government of Alberta, in consultation with RCMP management, encourage the Government of Canada to include a greater mental health component, provided by mental health professionals, in the training of new recruits to the force.

9. I therefore respectfully recommend that the Mental Health Act be amended to require in-patient facilities to provide the family physician, if known, with a copy of the patient's discharge summary, including any recommended treatment, within a stated period of time after discharge from an involuntary admission and to follow that up within a further period of time with an inquiry as to whether the patient has contacted his or her physician and to inform the patient upon discharge that they are required to do so.

## **5.2. Public Fatality Inquiry into the Deaths of Constables Anthony Gordon, Lionide Johnston, Brock Myrol, Peter Schiemann, and Mr. James Roszko (“Mayerthorpe Inquiry”) (Alberta, 2011)<sup>276</sup>**

This inquiry into the Mayerthorpe shootings of four RCMP officers before Associate Chief Judge Pahl of the Alberta Provincial Court was ordered in 2005 but took place over three weeks in 2011, after criminal proceedings against the perpetrator's accomplices were concluded.<sup>277</sup>

Four RCMP constables were killed by James Roszko in March of 2005 near Mayerthorpe, Alberta. Mr. Roszko then committed suicide. Two civil enforcement bailiffs had gone to Mr. Roszko's rural property to repossess a truck after Roszko failed to make payments. One of the bailiffs knew that Mr. Roszko had been reported to have placed a spike belt in his driveway in the past and requested a second bailiff accompany him. When they honked their horn at the locked gate, Mr. Roszko released two aggressive dogs. One of the bailiffs called the RCMP. Before they arrived, Mr. Roszko drove his truck toward the bailiffs and then drove off the property and out of view. Three RCMP officers arrived and entered the property to search for the truck being repossessed. They observed a marijuana grow operation and “chop shop.” The bailiffs posted their warrant on the door of the mobile home and left, along with one of the officers. The officers called in a “Be On the Lookout For” bulletin regarding Mr. Roszko. The bailiffs left while two officers remained at the scene awaiting the search warrant.

While the warrant was being prepared, officers considered and rejected the idea of having an Emergency Response Team (ERT) assist in executing the warrant. ERT was typically brought in to deal with suspects at known locations who are known or believed to be armed. Mr. Roszko's whereabouts were unknown, and it was unknown if he was armed. He was not known to be violent with police but did have a criminal record, including violent offences. He was subject to a weapons prohibition.

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<sup>276</sup> “Report to the Attorney General: Public Fatality Inquiry into the Deaths of Cst. Anthony Gordon, Cst. Lionide Johnston, Cst. Brock Myrol, Cst. Peter Schiemann, and Mr. James Roszko” (“Report of the Mayerthorpe Inquiry”). Justice and Attorney General of Alberta (March 2011), <https://open.alberta.ca/publications/fatality-inquiry-2015-march-27>.

<sup>277</sup> There was also a Human Resources and Skills Development Canada investigation, which is not yet in the Mass Casualty Commission's possession. In 2017, the Mounted Police Professional Association of Canada called for a judicial inquiry into the Pahl and HRSDC investigations: K. Muzyka. (2017). “Renewed Calls for Public Inquiry into 2005 Mayerthorpe RCMP Killings.” *CBC News* (29 May 2017), <https://tinyurl.com/ysy3wfvz>.

All twelve members of the Mayerthorpe RCMP detachment were involved in executing the warrant. They all carried a sidearm, a baton, pepper spray, and soft body armour; they also had shotguns and a .308 rifle at the scene. The officers cleared the buildings on the property, and the officers conducted the search. They discovered ammunition and intelligence on local detachments, including members' names, car numbers, and cell numbers. The search was suspended at 3:00 AM, and four officers remained to provide security until morning. Mr. Roszko had not been seen for twelve hours. The acting commander of the detachment, Corporal Martin, who was at the scene, considered it possible but unlikely that Mr. Roszko would return. They lit up the scene to make it obvious they were there, in order to deter Mr. Roszko from returning. Cpl. Martin and another officer left before 4:00 AM. The two remaining officers, Constables Johnston and Gordon, were considered well trained and exceptional members of their detachments. At 9:00 AM, Johnston reported that the night had been uneventful. Two other officers, Constables Schiemann and Myrol, arrived at the property at some point that morning. Two members from the Auto Theft unit arrived before 10:00 AM.

Mr. Roszko had contacted two other men, one of whom was involved in the grow operation at Mr. Roszko's farm. They dropped him off at his property between 1:00 AM and 3:00 AM, a mile west of a metal hut on the property. Mr. Roszko was not detected by any of the officers. At some point, he went into the hut. At about 10:00 AM, the four officers (Johnston, Gordon, Schiemann, and Myrol) entered the hut. Their reasons for doing so are unknown. Mr. Roszko shot the four officers; Constable Johnston fired back and Roszko shot him again. The four officers died immediately. Roszko left the hut. One of the Auto Theft unit officers, Constable Vigor, shot Mr. Roszko. Mr. Roszko then committed suicide.

Mr. Roszko's weapons were not registered to him. His associates, Shawn Hennessy and Dennis Cheeseman, had given him a Winchester rifle and ammunition that night. Mr. Roszko also had an H&K .308 semi-automatic rifle. It was legally imported into Canada, and Mr. Roszko likely purchased it in the 1980s. It subsequently became a prohibited weapon requiring registration. Mr. Roszko purchased a Beretta piston in Utah and apparently smuggled it into Canada. He also had a .22 Remington rifle and a shotgun, which were unrestricted weapons. Three remaining weapons were non-restricted and, according to the inquiry report, had been stolen from a location in Barrhead, Alberta, in 1997.

Mr. Roszko had a criminal record, including some thefts/stolen property offences from his youth, a sexual assault conviction in 2000 for offences that took place in the 1980s, and a conviction in 1990 for uttering threats. He was also charged with a series of offences including weapons offences in 2003, but the charges were dismissed. He had served more than a year in prison for the sexual assault conviction and was subject to a weapons prohibition. Mr. Roszko had faded from the local scene and had not had much involvement with the Mayerthorpe detachment in recent years. He had made twelve complaints against the RCMP between 1990 and 2000, which Corporal Martin knew. Judge Pahl concluded that Mr. Roszko would not have presented "as an individual who was likely to engage in a premeditated attack against the RCMP."<sup>278</sup>

Judge Pahl also commented on the fact that although Mr. Roszko had been prosecuted a number of times between 1993 and 2000, only one of these prosecutions had led to a record prior to his conviction for sexual assault, and he never met the criteria to be considered a dangerous offender. In an apparent reference to criticisms that the justice system had failed to prosecute Mr. Roszko

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<sup>278</sup> "Report of the Mayerthorpe Inquiry," p. 18.

properly, Judge Pahl emphasized the presumption of innocence, the requirement of proof beyond a reasonable doubt, and the use of prosecutorial discretion, before writing:

It may also be apparent that in a society such as ours, the rights and freedoms enjoyed by good citizens are equally enjoyed, and perhaps more often relied upon, by bad citizens. Finally, it will be obvious that rumour, speculation and innuendo will amount to nothing if charges are not laid, and of little more if such charges as are laid, are not proven.

The criminal legal system attempts to ensure that while most guilty parties are convicted, innocent parties should not suffer wrongful conviction. In the main, it succeeds in that pursuit, but it is not perfect and remains subject to the foibles of any human enterprise. It is inevitable that some guilt will not be established. It should not be controversial however, to say that in general, police, prosecutors and judges work hard to discharge their responsibilities and to exercise good judgment, common sense and fairness, all within the rule of law. To the extent that they succeed or fail is ultimately for others to decide and, unfortunately, is often determined in hindsight, a difficult standard as most will agree. Unfortunately, all this presents little comfort to the families here. They are, as Mrs. Johnston said, "... just looking for some answers". Regrettably, in many circumstances, and here, there are few clear answers as to why matters coalesce to a tragic end.<sup>279</sup>

Judge Pahl described Mr. Roszko as "an anti-social, petty criminal and likely, a sexual predator." His recent known involvements with the public, utilities, or RCMP had been focused on keeping them off his property, presumably because of the illegal grow op and chop shop on the premises. His decision to return to the property and kill the officers may have been fueled by anger that his operation had been interrupted and he would likely go to jail, and may have been fueled in part by his historical grievances against the RCMP. "He was clearly an antisocial individual and may also have been subject to a psychopathic disorder. In consideration of all this, his intentions may ultimately have been driven by suicidal ideation, as once confronted and wounded, he swiftly ended his life."<sup>280</sup>

Judge Pahl concluded that it was reasonable for the officers to believe that Mr. Roszko was not likely to return, particularly more than twelve hours after he had fled, and that this was a "uniquely tragic event which could not have been foreseen or prevented."<sup>281</sup>

Judge Pahl declined to make recommendations in a number of areas, for example, regarding the conduct of the Emergency Response Teams who were deployed after the officers were shot (but before it was known that they and Mr. Roszko had died) and regarding the availability of armoured vehicles. He also declined to make recommendations regarding sentencing, rehabilitation, statutory release, or correctional services.

He made the following findings in support of his recommendations:

- a. Although it is not clear that having more information would have affected the outcome of this tragedy, more information is better, particularly because threats to police have increased significantly in recent years. The Police Information Retrieval System (PIRS) in place at the time of the tragedy had been upgraded to the Police Reporting and Occurrence System (PROS), which gives members immediate access to background file information. As well, the RCMP had recently established a Behavioural Sciences Group, which was intended to be a dedicated criminal threat assessment unit with professional psychological support and access to a broader data base than detachments. Ad hoc

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<sup>279</sup> "Report of the Mayerthorpe Inquiry," p. 19.

<sup>280</sup> "Report of the Mayerthorpe Inquiry," p. 20.

<sup>281</sup> "Report of the Mayerthorpe Inquiry," p. 20.

approaches to threat assessment, such as individual members keeping their own threat lists, could lead to oversights and should be discouraged.

- b. The RCMP National Policy did not specify how a scene was to be secured or maintained, and there was no checklist or other written guidance requiring officers to, for example, put their minds to whether the individual is known to use firearms or to topography of the environment.
- c. The RCMP was heavily outgunned by Mr. Roszko. RCMP officers should be appropriately armed, but the RCMP does not give long gun training to its recruits. This is based on conclusion that long guns are not widely used, present a high risk of collateral damage, require individual adjustment, and proficiency in their use is highly perishable. An RCMP report<sup>282</sup> had recommended consideration of an Active Shooter Response Program, which would address the availability of patrol carbines for use by general duty members. Funding had been made available before the inquiry was complete for armaments, binoculars, night vision goggles, and other items. The RCMP report had also recommended that members wear sidearms when on duty. (Two of the officers killed by Mr. Roszko had been in plainclothes and unarmed.)
- d. The soft body armour worn by the officers who were killed is known to be ineffective against rifles. Human Resources and Skills Development Canada had ordered the RCMP to provide general duty members at the Mayerthorpe detachment with enhancements to their body armour to minimize risk from long gun threats. However, these enhancements are heavy, hot, and uncomfortable, and few general duty members wear them regularly. The RCMP and other law enforcement and military organizations were continuing to develop effective body armour to deal with this reality.
- e. The father of one of the officers who was killed had raised the question of whether there was a mechanism beyond local police initiative to trigger a threat assessment. For example, a psychological assessment at a prison facility could raise significant concerns but not reach the police. He also asked whether the threat assessment process had access to information, depending on the significance of the threat. Associate Chief Justice Pahl identified the fact that numerous complaints made by Mr. Roszko against the RCMP may never have gone beyond RCMP records as an example of the need for information-sharing for the purpose of threat assessment.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 1) Each detachment should designate a member (as distinct from staff) to fill the role of Threat Assessment Coordinator (TAC). This person would be primarily but not exclusively responsible for the collection and maintenance of master and individual threat assessment files. This member would be tasked to query members on a regular basis and to brief new members. The TAC would also liaise with the Behavioral Sciences Group as appropriate and in accord with criteria established by BSG. ... [T]hreat assessment would remain the collective responsibility of the detachment. All members would be charged with the responsibility to provide ongoing intelligence to the TAC, both formal and informal. This would include, and be recorded as such, speculation, rumour, and the staple of much good police work, the simple hunch. Finally, a formal system of transfer of TAC responsibilities should be established in order to ensure continuity. ... [T]he information collected in this effort should become part of any data base or would need to be promulgated beyond individual

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<sup>282</sup> The details of this report are not included in the report.

detachments, neighbouring detachments and the BSG. I recognize that this may eventually be seen as a natural progression and I caution that the appropriate privacy issues, given especially the breadth of the information I have recommended be recorded, should first be addressed.

2. (Recommendation 2) The RCMP consider the establishment of National Policy guidelines for the securing of potential crime scenes.
3. (Recommendation 5) That a standardized risk assessment system for high-risk, pre-planned operations be developed. This is an appropriate recommendation and adds to our earlier recommendation for threat assessment planning. I comment that some resistance to this specific suggestion has surfaced within the RCMP. Senior field personnel prefer to deal directly with a member who is requesting, for example, ERT assistance, rather than proceeding in accord with a pre-existing matrix. I agree with this view. The RCMP should resist excessive bureaucratization. Field operations require, as I have earlier stated, flexibility and freedom of action and I encourage future planners to remain cognizant of this fundamental fact.
4. (Recommendation 6) That an Emergency Medical Response Team program be developed to support high-risk operations. This has been started in Edmonton by the addition to ERT of one trained paramedic. All ER Teams should have at least one member with these capabilities.
5. (Recommendation 7) That a national policy directive be developed on unintentional discharges of firearms by ERT members. An unintentional discharge of a rifle carried by an ERT member occurred at Mayerthorpe. I have not commented on it as, fortunately, it turned out to be a benign incident, notwithstanding that it caused significant consternation at the time it occurred. The rifle was inadvertently discharged into the air without injury to the member or others. It is however, a subject for serious consideration as any such discharge, apart from its obvious direct dangerousness could, in the emergent circumstances of ERT deployments, create a cascade of misunderstanding, miscommunication and potentially, great harm. I am satisfied that the RCMP views these incidents seriously and is addressing them. That said, I recognize that ERT operations are inherently dangerous and that such occurrences may never be totally avoided.
6. (Recommendation 9) The Federal and Alberta Departments of Justice examine whether a formal system of threat assessment information-sharing, similar to that in respect of convicted sex offenders, between justice departments, correctional services, and police services, exists and if it does not, whether it might practically be established.

### **5.3. Independent Review of the Moncton Shooting (New Brunswick, 2014)<sup>283</sup>**

On 4 June 2014, a man wearing camouflage walked down the middle of a road in Moncton, NB, carrying two long guns and bullets. He walked into the woods. In response to 911 calls about this man, RCMP members went to the scene. The perpetrator, Jason Bourque, was moving among the woods and yards of homes in the area. He shot several RCMP members, killing three and wounding two others. The search for Mr. Bourque lasted 29 hours. On 6 June, he was captured. He pleaded guilty to three counts of first-degree murder and two counts of attempted murder.

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<sup>283</sup> "Independent Review: Moncton Shooting – June 4, 2014" Royal Canadian Mounted Police (2015), <https://www.rcmp-grc.gc.ca/en/independent-review-moncton-shooting-june-4-2014> ("Review of the Moncton Shooting"). This is a link to the publicly available, redacted version of this report. The Mass Casualty Commission has received a copy of the unredacted report, which is the source document for this scan.

The RCMP Commissioner appointed retired Assistant Commissioner Alphonse MacNeil to conduct an independent investigation into the event. The Commissioner directed Mr. MacNeil to examine thirteen specific issues and gave him 90 days to complete the Review. Mr. MacNeil's team was made up of RCMP investigators. They reviewed the Major Crimes investigation materials, Operational Communications Centre (OCC) transmissions, 911 calls, video footage, civilian and member statements, forensic evidence, and re-interviewed multiple members and civilians. They also attended the scenes with members who were directly involved. Mr. MacNeil noted that given the time allotted, he was limited in the depth to which he could explore certain issues. He also noted the effect of trauma on memories, which could have led some officers and other witnesses to have inaccurate memories or fail to recall what took place. Mr. MacNeil was unable to interview Mr. Bourque, as he was involved in the judicial process at the time of the report.

The first 911 call about Mr. Bourque came in just after 7:00 PM. Several other calls followed. Some callers reported concerns about the expression on Mr. Bourque's face. Many residents were outside. The area was made up of several wooded areas and streets with houses. Most of the houses did not have fences and had with trees and other features in the yards that would interrupt sightlines.

Several RCMP members responded to the 911 calls to set up a perimeter and patrol the area. Only one member had a shotgun, and he had had to sign it out. The other members carried pistols. Some members walked into the wooded area, which was very dense, with poor visibility. They requested police dog services, which were delayed. Other members arrived and took up positions in the area. Several of them arrived with sirens on, which would have alerted Mr. Bourque to their arrival. One of the officers, Constable Daigle, saw Mr. Bourque cross a road into another wooded area and tried to follow him. Constable Daigle reported this sighting, and members began to adjust the perimeter accordingly. They also told residents to go into their homes. Another officer tried to broadcast a description of the suspect, but radio static made it difficult to understand. Constable Daigle and another member, Constable Gevaudan, saw Mr. Bourque move toward a backyard and moved around the house. Constable Gevaudan had his pistol drawn and was only partly concealed from Mr. Bourque. Two members arriving in the area by car broadcasted their arrival on the radio just as Constable Gevaudan directed members to "clear the air." Mr. Bourque turned, saw Constable Gevaudan, and fired three quick shots. The shots missed Constable Gevaudan, who radioed while running from the area that he was being shot at. Constable Gevaudan did not know the area; the path he took brought him into an open, more exposed area. Mr. Bourque fired two more shots, killing Constable Gevaudan.

Mr. MacNeil concluded that the initial member response was robust and appropriate. The Operational Communications Centre, which under Codiak Detachment policy is responsible for containment and perimeters, did a "commendable job"<sup>284</sup> in obtaining information from 911 calls and broadcasting it and in directing members to contain Mr. Bourque and isolate him in the wooded area. Members who knew the neighbourhood helped to make the perimeter as effective as possible.

Initially, the Codiak detachment was the centre of operations and the acting Sergeant, Corporal Cloutier, acted as the Operations NCO. He called in and deployed resources for containment and properly managed and coordinated the response to the initial call. AC Mr. MacNeil concluded that

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<sup>284</sup> "Review of the Moncton Shooting," p. 52.

Corporal Cloutier was hampered by inadequate mapping and by the fact that members could not be tracked by GPS on foot once they left their vehicles.

Corporal MacLean, the road supervisor at the scene, acted appropriately by requesting additional resources, ensuring the perimeter was held, advising members not to venture deep into the woods, and instructing civilians to leave the area. However, at the moment Constable Daigle spotted Mr. Bourque, Corporal MacLean had left his car to go to the scene on foot. His radio detached from his belt as he left the car, and he did not have a cell phone. He was therefore not able to communicate with Constable Daigle. When members left their vehicles to help Constable Daigle track Mr. Bourque, they left their hard body armour behind and could only communicate their locations by radio, making it difficult for the OCC and supervisors to know where they were at any time.

After shooting Constable Gevaudan, Mr. Bourque ran through some backyards onto another street. The dog handler, Constable Ross, was arriving in the area. He may have known that shots had been fired but would not have known that a member had been shot. Constable Ross saw Mr. Bourque across the street from two civilians, who had stopped their car. Mr. Bourque was walking while moving his rifle from one hand to another. Constable Ross said, "Got a visual, will be on takedown in a second" and accelerated towards Mr. Bourque. Mr. Bourque turned toward him. Constable Ross turned on his lights, drew his pistol, and fired two rounds through his windshield at Mr. Bourque. Mr. Bourque fired six rounds at Constable Ross, killing him instantly. This took place two minutes after Constable Gevaudan was killed.

Mr. MacLean noted that because Constable MacLean, the road supervisor, did not have a radio, he did not know that Constable Ross was planning to accelerate towards Mr. Bourque and could not have provided any direction. Constable Cloutier also had little awareness of what was happening. Mr. MacNeil made reference to the emotional gravity of the situation and the impact of a lack of training and experience with this type of tragedy.

Three members found Constable Gevaudan and moved him after detecting a faint pulse but no breathing. Corporal MacLean, the road supervisor, left to pursue Mr. Bourque. He did not discuss a tactical plan with the other members before leaving, and no one established a command presence during this period. Another member, Constable White, heard the shots fired at Constable Ross and ran to Constable Ross' car. Constable White could see that Constable Ross was dead. Constable White saw Mr. Bourque, who was nearby, begin to take aim at him and took cover behind Constable Ross' car. Mr. Bourque went toward another wooded area. Constable White reported Mr. Bourque's location and that Constable Ross was "down." Corporal MacLean then broadcasted that they needed the Emergency Response Team (ERT).

Mr. MacNeil concluded that Constable White's decision not to engage Mr. Bourque was tactically sound, given the distance between them and the inferior weapon Constable White possessed. Immediate Action Rapid Deployment (IARD) training requires members to move toward the sound of gunfire and engage the shooter, in order to reduce casualties. Most of the members followed that training and tried to move toward the shooter in an effort to stop him even after Constable Gaudavan was shot. Mr. MacNeil noted that Constable White, who was an IARD instructor, did not feel that IARD was the appropriate tactical response.

After the first two officers were shot, two more officers, Constables Benoit and Gilfillan, were sent from the office, and three members of the Major Crimes Unit returned to the detachment to obtain shotguns and respond as backup. Constable Benoit arrived with lights and sirens activated, near where a civilian had reported seeing Mr. Bourque. Mr. Bourque had just entered the woods.

Constable Benoit started opening her door; Mr. Bourque fired at her car from the woods and disabled her car. Constable Benoit stayed down and used the engine block for cover, which Mr. MacNeil described as “the best reactionary tactics possible.”<sup>285</sup> She radioed that she was being shot at from in front of the vehicle, but she couldn’t see the shooter. Constable Benoit repeatedly asked for help and asked if it was safe to leave her car. Mr. MacNeil concluded that Constable Benoit’s decision to stay in her car, calmly radio that she was being fired upon, and then request assistance was appropriate.

Constable Dubois, who was stationed nearby to block traffic, moved to Constable Benoit’s location and parked his car beside hers to provide more cover. Mr. Bourque fired at them and injured Constable Dubois, who ran to the fire station. Constable Benoit was picked up by another constable, who drove her to the fire station. Mr. MacNeil concluded that Constable Dubois’ actions to help Constable Benoit were also appropriate.

Constable Goguen, a member from the neighbouring Southeast District, had learned about the situation in Codiac. She was instructed to go to the Hildegard Fire Station. Southeast District members use a different radio frequency, and the OCC did not know Constable Goguen was attending the scene, nor did Constable Goguen know that she was driving directly to the shooter’s location. When she arrived, she saw several civilian cars doing U-turns on the street and heard gunshots. She was turning her car around when Mr. Bourque shot and wounded her. Mr. MacNeil concluded that her quick decision to move her car as she heard gunshots and while being shot at helped save her life. Because Constable Goguen was on a different radio frequency, the Codiac members were unaware she had been shot. They found her bullet-ridden car after she had moved and parked it and mistakenly assumed her car had been shot in that location. This added to confusion about Mr. Bourque’s movements.

Mr. MacNeil noted that during this period, tactical awareness was poor. No individual member took charge over the radio, so OCC dispatchers did their best to coordinate operations. It would have been nearly impossible to form an accurate tactical view of the situation, given inaccurate reports coming in, sightings being broadcast out of order, and other factors.

At this point, there was a lull in the shooting. There was confusion over how many officers had been shot, where the suspect was, and where ambulances were needed. There were also erroneous reports coming in about where shots had been fired and where the gunman was. Ambulances were not permitted to enter the area of an active shooting, and eventually Constable Goguen and Constable Dubois were taken to hospital by their colleagues. Mr. MacNeil noted that during this period, members were acting on their own, without a plan. No supervisor had an overall view of where the members were and did not learn this for an hour or more. No scribe was assigned to record decisions, resource allocations, member positions, or other important information. There was no supervisory direction to members. Corporal MacLean later said he was leaving it to the OCC to direct members because they had the mapping system and the vehicle location data. Corporal Cloutier, the Operations NCO, did not have adequate situational awareness to provide proper tactical direction. Mr. MacNeil found that although the OCC was doing an exceptional job in coordinating the members on scene, a senior NCO with tactical experience posted to the OCC would have been able to coordinate resources with real-time, accurate information.

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<sup>285</sup> “Review of the Moncton Shooting,” p. 44.

There had been steady foot and vehicle traffic by civilians throughout the incident, but Mr. Bourque had only shot at police officers. Members therefore knew he was targeting police and took cover at the fire hall. However, because Mr. Bourque's whereabouts were unknown, the fire hall was not a safe location. Video from the fire station showed a lack of coordination and supervision. No one directed anyone to block either end of the road; one member offered to block westbound traffic at one end, but no one blocked the other end. When the Major Crimes Unit members arrived, they were not given a duty. One of these members, Constable Larche, broke off and went to look for Mr. Bourque. He got out of his car with a shotgun. Mr. Bourque saw Constable Larche and recognized that he was a police officer because he was wearing soft body armour. Mr. Bourque shot at Constable Larche through his police car. Constable Larche fired back. Mr. Bourque shot Constable Larche in the head, killing him at 8:07 PM. Mr. Bourque fled into the woods. The members held their positions and did not pursue him further. Mr. MacNeil concluded that this was a tactically sound decision.

After the shooting of Constable Larche, there should have been a period of stabilization and coordination. However, this did not happen. Many members were not briefed and took it upon themselves to respond without any person in charge being aware. No one was keeping track of the locations of members on the perimeter or shift duration. Some members worked more than 24 hours without replacement. No roll call or situation update was conducted, and members did not receive a detailed update from a supervisor.

The Codiac Operations Officer, Inspector Vautour, arrived at 8:20 PM and became the Incident Commander at that point. A scribe was appointed, and people were given specific tasks; but the execution of those tasks was not monitored, and the command structure was not clear to those on the ground. There was no official briefing or transfer of command, and Constable Cloutier, the Operations NCO, was not advised that he was being replaced by a more senior member. He believed he was in charge until he went home the following morning. Members also were unclear who had supervisory responsibility. Corporal Cloutier and Inspector Vautour were very busy, the situation at the detachment was hectic, and information was coming in from numerous sources. They were overwhelmed by the information coming in, and unable to effectively process it. Neither Corporal Cloutier nor Inspector Vautour had Critical Incident Command experience or training. There was no broadcast by a commander to the members regarding the specific threat they were facing. Some members learned about it through word of mouth; some members on scene did not know how many had been killed until hours later.

Inspector Leahy was the assigned Critical Incident Commander (CIC). He arrived in Moncton in the middle of the night and decided to move the Command Post from the Moncton Coliseum to the Moncton Garrison. He focused on setting up the new command post and left Constable Cloutier and Inspector Vautour to act as incident commanders until he took command at approximately 3:00 AM. Mr. MacNeil noted that the CIC should have delegated the establishment of the command post to someone else and focused on his command role, and should not have delayed taking operational control. The two officers left to act as incident commanders during this period did not have formal incident command training.

There were no proper debriefings when members were sent home the next morning. Many of the members who came from other police agencies and districts said they did not receive directions and just "drove around", which could have proved very dangerous.

Police from other districts and detachments, municipal agencies, and members from "H" Division (Nova Scotia RCMP) started arriving in Moncton in response to the Codiac RCMP Detachment's request for resources. There was no mechanism to track or coordinate these resources, and

members did not receive direction on where to go or what to do. Nova Scotia police officers were unable to communicate by radio with Codac OCC and could not be tracked. They were only able to use cell phones to communicate until portable radios were distributed; due to the load on networks, these cell phones were not reliable. Unconfirmed sightings of Mr. Bourque were broadcast via radio. Members did not maintain set positions within the perimeter and moved around in response to these broadcasts without informing anyone in charge (or clarifying who was, in fact, in charge). They were not told to report their positions, and no one was keeping track of their positions, weaponry on site, or how long any of the members had been on shift. While the members were hunting for the gunman, they were also investigating the scenes of the murders and attempted murders, with protective perimeters around the sites. This period was described as chaotic and disorganized.

For 29 hours, Mr. Bourque hid in the woods. He was close to large numbers of officers at all times during this period. The incident commanders were aware that Mr. Bourque had a significant tactical advantage and could fire on anyone at any time. Late in the evening of 5 June, a resident in a house by the woods reported seeing a man crouched outside below the kitchen window. The man, Mr. Bourque, ran into the woods. ERT members on TAVs came to the area. An RCMP helicopter flew at low orbit, within a range which could allow its Forward Looking Infrared (FLIR) heat detecting imaging to detect Mr. Bourque's heat signature. The helicopter did not detect that heat signature. It ran low on fuel and returned to the airport for refueling. A Transport Canada Dash-8 aircraft with newer FLIR technology circled at a higher altitude. It eventually detected Mr. Bourque's heat signature in the woods. Mr. Bourque's movements suggested that he had been hiding, which allowed him to avoid detection by the helicopter's FLIR device, heard the helicopter leave, and then emerged from hiding to change location.

The Command Post coordinated nearby ERT members to isolate and contain Mr. Bourque. Although images taken by the Dash-8 were downlinked to the command post, ERT members at the scene could not see them. The Dash-8 had an infrared laser designator, visible only with a night-vision device. It used this designator to illuminate Mr. Bourque. However, only one member of the ERT team closest to Mr. Bourque had a night-vision device. He had to relay his observations to the other team members. This member ordered Mr. Bourque to come out with his hands up. Mr. Bourque said, "I give up, don't shoot!" and came out of his hiding place with his hands up. He had left his weapons behind.

Mr. MacNeil noted that because Mr. Bourque was armed, wearing camouflage, hiding among the trees, and appeared to be displaying actively resistant behaviour, those facts should have raised the risk assessment of the responding members significantly. One of the members observed that Mr. Bourque appeared to be irritated, which also should have heightened the responders' risk assessment. All members approaching Mr. Bourque should have been ready to respond immediately with lethal force if necessary.

Mr. MacNeil found that the police in Moncton commonly receive calls regarding guns, and the majority involve no real threat to public safety as they relate to paintball or air guns, or hunters. RCMP policy and the Incident Management Intervention Model (IMIM, the RCMP model for risk assessment and management<sup>286</sup>) categorize this type of call as high risk, but some members stated that they get these types of calls "all the time." Mr. MacNeil noted, "While training teaches that these are high-risk calls, experience feeds into cognitive biases, which lead to the discounting

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<sup>286</sup> "Incident Management / Intervention Model" Royal Canadian Mounted Police webpage (modified 17 January 2022), <https://www.rcmp-grc.gc.ca/en/incident-management-intervention-model-imim>.

of risk. The lack of shotguns and worn HBA in the initial response is indicative that experience had undermined training regarding individual risk assessments.”<sup>287</sup>

Mr. MacNeil concluded that once they sighted Mr. Bourque a second time, the officers should have used verbal intervention with lethal force over-watch. Lethal force over-watch refers to having one or more designated members train their firearms on the suspect, while other intervention options are attempted. The member whose firearm is trained on the suspect scans for threat cues and can engage with the suspect if necessary. In order to deploy lethal force over-watch effectively, communication between members as to who takes what role is essential.

Mr. MacNeil suggested that once Mr. Bourque shot Constable Gevaudan, a preferable approach would have been for members to seek cover, conduct a risk assessment, establish a rescue plan for Constable Gevaudan, and establish a plan to neutralize the threat. A plain-language broadcast stating that the suspect had just shot a member with a high-powered rifle should also have been made, which could have changed the risk assessment of the second wave of members arriving at the scene, none of whom used hard body armour. The lack of such a broadcast could have been due to the members’ efforts to provide first aid to Constable Gevaudan in a highly emotional situation, while in a tactically dangerous position.

### **Containing and Tracking the Suspect**

No efforts were made to set up checkpoints, to monitor major transportation routes, points and exits within New Brunswick, to notify ferries, bus services or other transportation services, or to take any other steps to prevent Mr. Bourque’s escape from Moncton. Mr. MacNeil noted that the RCMP did not know that Mr. Bourque was acting alone and did not have a vehicle.

IARD training at the time used scenarios involving an indoor school shooting, and did not include any outdoor scenarios. Although the first responding members followed their IARD training to search for Mr. Bourque, their ability to track him through the urban neighbourhood may have been hampered by that lack of outdoor training.

### **Communications between RCMP Members**

A single municipal employee was the primary dispatcher who coordinated the initial perimeter. She did so effectively. However, the flood of information into the Operational Communications Centre (OCC) was beyond the capacity of one person. She was the only person with direct communication with frontline members and was coordinating members and information with the Computer Integrated Information Dispatch System (CIIDS) mapping system. There was no member to assist her and no supervisor at the OCC. Only 911 calls were being answered because the systems were overloaded. Issues in the training of OCC call takers and dispatchers, and the fact that Codiac OCC does not report to the “J” Division Support Services Officer, were identified in the Review Report but redacted.<sup>288</sup>

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<sup>287</sup> “Review of the Moncton Shooting,” p. 107.

<sup>288</sup> The Review did not address the response of Codiac detachment to the initial calls from the public. Media reports suggest that the detachment responded to one of the first calls from a community member by saying, “Are you sure it’s a real gun?” and “What makes you think that he’s a threat?” See T. McMahon et al. (2014). “The Untold Story of Justin Bourque.” *Maclean’s* (15 June 2014), <https://www.macleans.ca/news/canada/untold-story-justin-bourque/>.

Poor radio protocol contributed to poor situational awareness during the period of initial response. Because the radio was not encrypted, members were not using plain language during transmissions, causing confusion as to the severity of the situation and making it difficult for supervisors to give direction. Supervisors were reluctant to talk over the radio because they did not want to tie up vital airtime, which could prevent a member in direct danger from communicating. Constable Cloutier, the Operations NCO, was too busy monitoring radio traffic, making calls, and managing other logistics to manage the situation effectively, and he did not have anyone to whom he could delegate tasks.

Radio-based communication, dispatch, and locating technology are operationally managed by the OCC. The OCC in Fredericton services all RCMP detachments and units except for Codiac and a second OCC serving Codiac and certain fire services. The Codiac OCC has six staff on any given shift. The Codiac radio system does not have Automatic Numeric Identification (ANI), which allows members to be immediately identified when keying the microphone without the dispatcher having to recognize the member's voice. There were occasions when members keyed the microphone but could not be understood. Had ANI been in use, the OCC would have known who was trying to call. The lack of clarity in radio communications and the failure of supervisors to direct members to state clearly what was occurring impeded situational awareness. Trying to use the 10-code and phonetic alphabet is time consuming and can be dangerous.

Although the area where the incident occurred had excellent coverage for mobile and portable radios, there were gaps in areas outside the city of Moncton. The system in place in Codiac allowed users to "over talk" other transmissions, which can prevent an emergency transmission while another person is talking and can lead to garbled and incomprehensible transmissions when multiple members broadcast at the same time; both situations occurred during this incident.

As with the rest of "J" Division and most other contract policing divisions, Codiac detachment general duty radio communications are not encrypted, and there is limited availability and use of encrypted systems. This led members to feel they could not relay important and specific information by radio in case Bourque and/or "news chasers" were monitoring transmissions. That led to significant problems with risk assessment.

Codiac detachment used only one of two frequencies during this incident rather than, for example, having perimeter members on one and responders on another. This led to the system becoming overloaded quickly. Other jurisdictions have primary channels for emergency communications and secondary channels for non-urgent communications; some provinces have a dedicated radio channel for "mutual aid," whereby other first-response agencies can communicate with each other. There was also no user guide for the detachment, so some units from outside Codiac did not know which channel to use. There were also potential problems with automatic reversion to home channels, the details of which were redacted from the Report.

The Director of Strategic Communications in "J" Division and the Moncton strategist both learned of the incident from the media rather than from the RCMP. There were also difficulties obtaining relief for communications staff after the incident.

### **Interoperability**

Mr. MacNeil noted problems with technological interoperability during the incident. For example, Constable Goguen responded from a neighbouring district and drove directly into gunfire without knowing it, as she was using the Fredericton channel. In 2007–08, there had been support for creating one radio system for all emergency responders in the Maritimes, but provincial funding

challenges had prevented it from being implemented. There was also no way for the Codiac OCC to track or monitor the officers from other divisions, and those members had to rely on their own OCC, which did not have situational awareness and could not contact the Codiac OCC because its telephone and radio systems were overloaded.

### **Command and Control**

Mr. MacNeil identified the supervision structure of the RCMP relating to critical incidents as follows:

1. Until command is taken over by a Critical Incident Commander (CIC), it is the responsibility of the general duty supervisors to manage the incident.
2. During a critical incident, the tactical level command on the ground is managed by an accredited CIC.
3. For major events, national crises, or incidents requiring centralized coordination, the Division CrOps (Criminal Operations) may order additional staffing of the Divisional Emergency Operations Centre (DEOC) to coordinate RCMP resources and external partners. The CO/CrOps Officer retains control and authority for the operation.
4. RCMP National Headquarters, through the National Operations Centre (NOC), provides national policy guidance, manages and co-ordinates information and resources among the Divisions, sets strategic priorities, and serves as the coordination and communication link with other federal government departments and agencies. It operates 24 hours a day, 7 days a week and performs both routine and crisis operations. During an emergency operation, liaising with other federal departments and agencies and Public Safety Canada should, at the national level, be conducted through NOC.
5. The RCMP manages critical incidents by establishing critical incident response teams, consisting of a CIC and an ERT team and Crisis Negotiation Team (CNT), who report to the CIC. The CIC commands the incident, including liaison with all support services, direction of human and material resources, deployment of resources, the interaction of those resources, and maintaining the integrity of the command triangle.

The CIC identified the mission as locating and arresting Mr. Bourque, while keeping the safety of the police, public, and Mr. Bourque in mind.

Mr. MacNeil stated that chaos is unavoidable in the first moments of a dynamic situation, but order should be restored as quickly as possible through supervisory coordination in the form of Command and Control. "Structure, even when the structure is not perfect, is expected by members in a crisis."<sup>289</sup> Lack of communication and poor situational awareness impeded the establishment of command and control. Mr. MacNeil noted that research on active shooting incidents has found that when command and control is not formally established, there is increased failure to share information across responder groups.<sup>290</sup> This can lead to information gaps and delayed responses and can compromise first responder safety.

Frontline RCMP supervisors did not receive formal training on tactical supervision or command and control. IARD training at the time had no supervisor component, and none of the supervisors involved in the initial response had training or experience in supervising critical incidents. Mr.

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<sup>289</sup> "Review of the Moncton Shooting," p. 61.

<sup>290</sup> Mr. MacNeil did not identify this research.

MacNeil said, “The supervisors involved in this incident were faced with circumstances very few will ever experience. While it is recognized the level of supervisory competence required in the first hour of this incident was extraordinary, police are routinely involved in managing crises and supervisors should have an ability to take charge.”<sup>291</sup> He noted that there was a five-day training course that covered some of the principles required to manage events such as this, but it was unreasonable to expect every supervisor to attend this course. He suggested that the RCMP should promote a culture in support of training to improve competency around tactics and command.

The CICs did not write out a specific operational plan for each deployed tactical unit. The only documentation regarding tactical planning was the briefing board/flip charts and CIC scribe notes, which was not in accordance with RCMP policy and training and would be inadequate in the event of a trial or inquest. The CICs told Mr. MacNeil that they were not able to write specific operational plans because the situation was too fluid and unfolding too quickly. Mr. MacNeil noted that they had 29 hours over the entire operation, which should have allowed them to write out specific operational plans for the teams. He also noted that because there were no written plans, some of the ERTs did not receive adequate detail around how specific operations would be executed. The scribe notes did not capture the decision-making process of the CIC or changes to strategy made in response to changes in the situation.

### **Technology, Equipment, and Weapons**

Although Mr. MacNeil did not have the time to review available technology that could have assisted in the coordination during this incident, he made recommendations for “common operating picture” and other resources to be explored. He concluded that the “J” Division Emergency Operations Centre was not in a state of readiness when it was activated, there were technical problems caused by a lack of a maintenance schedule for DEOC equipment, there were no news media feeds within the facility, there was no dedicated communications room, and there was no access to the NOC web-mapping service.

The Computer Integrated Information Dispatch System (CIIDS) uses status, mapping, integration with CPIC, PROS and PIP, internal messaging and other features. Current CCIDS mapping was not adequate, and its terrain imagery was significantly inferior to web-based systems, including the system available to the NOC through the Infoweb. The NOC service would have given the OCC and Operations NCO a significant advantage. Mr. MacNeil noted that the OCC, Operations NCO, CIC, and DEOC should have been able to share positional data. However, the unit responsible for managing this service, the Geospatial Intelligence Section, consists of one member in Ottawa. That member does not have the capacity or mandate to deploy this resource to the RCMP.

Tactical armoured vehicles were an important feature of this mission, as they can move members close to the threat while protecting them from gunfire. However, there were a number of issues with respect to the use of TAVs. Because only ERT members are trained to drive TAVs, this reduces the number of ERT members available for other duties (such as sniper duty). Mr. MacNeil also noted the poor mechanical record of the TAVs, which were custom made for the RCMP to provide greater ballistic protection than would otherwise be available. Those TAVs coming from long distances were driven at lower speeds to reduce the risk of breakdown; one did break down. The TAVs were also poorly air-conditioned, requiring members to open the hatches – which of

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<sup>291</sup> “Review of the Moncton Shooting,” p. 63.

course reduces their protection from gunfire. Mr. MacNeil also identified the need for improvements in training for ERT members to ensure they are optimally using the vehicles' capabilities. The training is not uniform across ERT teams. TAVs are also not designed for off-road use, although that was not an issue in this mission. The aircraft providing surveillance was not able to distinguish the TAVs from each other, and there was no electronic means of identifying them, so Incident Command misidentified some of the several TAVs and instructed them to reposition during the arrest. That could have resulted in a cross-fire situation, had the officers been required to fire on Mr. Bourque.

The RCMP used armoured vehicles from Brinks until RCMP TAVs arrived. Mr. MacNeil noted that the Canadian Forces Base at Gagetown would have likely had armoured vehicles, drivers, aircraft and ground trackers who could have deployed to Moncton on short notice. The RCMP are able to request Canadian Armed Forces assistance, including the use of equipment where specialized or unique capabilities are required; Mr. MacNeil noted that this assistance should be considered in these types of situations.

Aircraft surveillance provided significant assistance to members by avoiding a need for a very risky ground search, and other aircraft transported members and equipment to the site. However, there were challenges scheduling and coordinating the use of aircraft during the incident. This was in part ascribed to the fact that no Air Services liaison was embedded within the command post to assist the CIC.

The RCMP helicopter based in Moncton was deployed soon after the OCC learned an officer had been shot. It was equipped with an older form of heat detecting technology (FLIR), which malfunctioned twice during the incident. The technology required it to fly closer to the ground than aircraft with the newer FLIR technology, putting the crew at greater risk from ground fire. It was also unable to map locations on the ground through GPS. Although the RCMP had newer systems in stock, they had not been installed, apparently due to conflict over who would pay for the installation. Mr. MacNeil identified the significant tactical advantage provided by having aircraft capable of identifying the heat signature of a suspect who is trying to hide. "Should the suspect move, this information is available in real-time and the team can redeploy accordingly. An aircraft can pin down a suspect who knows that his movements are visible from above, night or day. Someone can hide their thermal signature, but they cannot move about while doing so and are thus immobilized."<sup>292</sup> The newer heat signal detection systems, including that carried by the Dash-8 aircraft, are also able to illuminate the suspect with an infrared beam, but that beam can only be seen with night vision devices. ERT members with infrared designators on their weapons can illuminate suspects the same way. Members need to be trained and equipped in order to benefit from these systems.

Between the time of the initial call and the point the last shots were fired, 24 RCMP members responded. Eighteen were wearing the working uniform with soft body armour and a loaded pistol; four were in plain clothes with soft body armour, three of whom had shotguns; one wore a uniform with soft body armour and a pistol; and one was in a Forensic Identification Section uniform with soft body armour and a pistol. Prior to this incident, it was unusual for Codiac members to sign out shotguns at the start of their shifts. The shotguns were kept in a locked cabinet, likely due to the low demand. The practice had since been changed to provide members with ready access to shotguns and rifles.

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<sup>292</sup> "Review of the Moncton Shooting," p. 79.

Mr. MacNeil discussed the capabilities of the various weapons available to the members who responded during this period, noting that detachment rifles and patrol carbines can strike targets accurately at distances far greater than the shotguns or pistols the Codiak members had during this operation. Annual qualification with detachment rifles was no longer required, and very few of the first responders had qualified with it. The detachment rifle is also slower to fire.

Codiak did not have any general duty members trained to use carbines, and the detachment's carbines, which had only recently been provided, were at Gagetown for "J" Division's first carbine training course at the time of the incident. (See discussion below regarding the delays in providing carbines to RCMP members.) However, several members had previous Canadian Forces training on the military version of the carbine and would have been permitted to use one, had one been available. Mr. MacNeil identified several stages of the incident at which possession of a carbine could have made a significant difference.

The use of Hard Body Armour would not have saved lives or reduced the severity of wounds in this incident. However, Mr. MacNeil noted that there was not sufficient HBA for the members deployed to the scene and that one member opted to go without in order to allow her colleague, who had children, to use hers. Many members on perimeter duty did not have HBA, and some who had it were not familiar with how to wear it.

Basic weapons training at Depot did not present cadets with scenarios involving the kind of risks members experienced during the incident. Annual qualification requirements consisted of a test to determine if the candidate could hit a target in a specified time rather than the extensive training and practice required to be able to hit a target at long range, while moving, after physical exertion. Some members were seen on surveillance video without their pistols drawn or with their shotguns over their shoulders, and one accidentally discharged his shotgun while running. Mr. MacNeil concluded that the limitations of the yearly qualifications may have led these members to handle their weapons in a "non-tactical manner."<sup>293</sup> Mr. MacNeil also noted that some members were not qualified to use the firearm they were carrying.

Mr. MacNeil noted that splitting tactical situation training into various training modules had the effect of compartmentalizing situations. "J" Division had moved toward combining lectures and practical scenarios and had already implemented some lessons from the incident to modify their tactical training approach at the time the Report was published.

Mr. Bourque had five non-restricted firearms in his possession during the incident, including a .308 Winchester rifle with two prohibited magazines. Mr. Bourque said later that he was aware that the Winchester bullets would penetrate soft body armour. He also had an M305 semi-automatic rifle; he had removed the legally required modifications to allow the magazine to hold more cartridges.

### **Coordination of Resources**

Because the deployment of members in the immediate aftermath of the shootings and for several hours afterwards was chaotic, the perimeter was not coordinated properly. The global positioning system (GPS) devices in member vehicles from other jurisdictions could not be tracked in "J" Division, so the CIC could not track their locations. It took several hours before the CIC became aware of where and how the resources had been deployed; this is something he should have been aware of immediately upon taking tactical control of the incident. Mr. MacNeil noted that Mr.

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<sup>293</sup> "Review of the Moncton Shooting," p. 108.

Bourque said in his statement that he did not fire upon members where there were several of them in a group because he felt he would be overmatched. Thus, members who were deployed on perimeter duty in groups were less likely to be fired upon.

The RCMP National Operations Centre has well-developed standard operating procedures for coordinating resources between the RCMP and federal partners that have been proven effective in other incidents. However, it was not activated. This impeded intergovernmental coordination and the efficiency and effectiveness of resource requests.

The Specialized Crisis Negotiation Team (CNT) were properly deployed and took the required steps to be ready in the event that contact was made with Mr. Bourque. They coordinated with the ERT and with a mental health professional.

### **Emergency Response Team**

Mr. MacNeil identified the inability of the Command Post to track individual ERT members or vehicles on the ground as a “huge tactical liability.”<sup>294</sup> This prevented incident commanders from effectively coordinating their movements. During the arrest, the two ERT teams closest to Mr. Bourque were not ideally positioned, leaving them susceptible to cross-fire if any of them had fired at Mr. Bourque. Mr. MacNeil noted that the ERT program was evaluating equipment and applications which would allow GPS tracking of their members.

As noted above, infrared illuminators on aircraft and weapons require night vision devices to be seen. Because only one member of the ERT team closest to Mr. Bourque had a night vision device, that member had to relay their observations to the other members. This required them to be positioned closer together than is optimal, and made them more audible to Mr. Bourque. Mr. MacNeil also noted that the ERT training program generally trains in daylight. He concluded that maximizing ERT’s ability to act on airborne electronic surveillance requires standardized training and procedures developed in conjunction with Tactical Flight Officers, as well as the proper equipping of ERT members. ERT members’ uniforms and equipment should also be standardized across divisions. This would allow for interoperability. Standardized uniforms would also reduce risk:

In Moncton, the suspect was known to be wearing a camouflage uniform. There is a danger in having teams wear camouflage uniforms which differ from one another as they will not be instantly identifiable as belonging to the police. A delay in positively identifying a member versus an aggressor, based on their clothing, could prove fatal in a close-combat situation. Whereas local vegetation dictates what type/pattern of camouflage clothing is most effective for individual teams, collective rural and urban standards would be advantageous when teams work together.<sup>295</sup>

Mr. MacNeil concluded that while other reports (not identified) have recommend having all ERT members be full-time and that this would ensure they have time to develop and maintain their “highly perishable” skills, this would not be realistic given the limited resources available in some jurisdictions.<sup>296</sup>

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<sup>294</sup> “Review of the Moncton Shooting,” p. 78.

<sup>295</sup> “Review of the Moncton Shooting,” p. 82.

<sup>296</sup> “Review of the Moncton Shooting,” p. 82.

## Public Alerting

At the time the incident began, the radio stations in Moncton had either switched to national programming or were broadcasting pre-recorded programs. The next local TV broadcast was scheduled for several hours later. The local newspaper's website was behind a paywall. Social media was therefore the quickest and most effective way to reach people.<sup>297</sup>

The Moncton communication strategist presented completed tweets for approval. The initial tweets said there was an active shooter in a residential neighbourhood and that residents were to stay in their homes, and others were to stay away. There were several updates. Once the number of officers shot and killed was confirmed, that information was posted to quell community concerns that civilians had been shot. The RCMP also used social media to provide information to reporters, as the phone lines were deluged, and it was impossible to call back individual reporters. The media team attempted to post a new message on social media every thirty minutes so that followers would receive timely updates. Mr. MacNeil stated:

Having a continuous presence on social media during this crisis ensured accurate information was disseminated in a timely manner so as to counter any rumours or misinformation. It also acted as a calming tool, so that the heightened fear in the community did not escalate and affect public safety and security. Providing messages with a "call to action" that asked the public to engage allowed them to participate without interfering with police operations and did not leave them wondering what they could do.<sup>298</sup>

Mr. MacNeil noted that the RCMP did not have a mechanism for tracking responses to the posts, including tips from members of the public. Communications staff also did not have proper equipment for posting social media updates and had to use their personal devices.

## Post-event Communications with and Support for the Public

Following the event, there were several news conferences. However, there was no spokesperson addressing the operational side of the investigation. Mr. MacNeil suggested this should not be left to the CO or OIC. There were also too few communications staff to manage the post-event communications, including the regimental funeral. Following the event, the National Communications Services (NCS) collaborated with other departments to create an online tool, which allowed members of the public to submit digital photos and video evidence relevant to the investigation.

The Report noted the "J" Division webpage titled "Setting the Record Straight," which it uses to correct factual errors in the media or rumours in the community. Mr. MacNeil credited a message posted on this page during the investigation with shutting down the rumour mill and gaining community support.

The Communications unit, along with staff relations representatives, made itself available to give the families of fallen members advice on how to deal with the media. Mr. MacNeil described the care provided to RCMP employees and their families after the events as follows:

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<sup>297</sup> The incident took place several years before the Alert Ready system for sending emergency messages to cell phones was established. However, the system for emergency television and radio broadcasts was in place at the time of the incident. The Review Report makes no reference to this system.

<sup>298</sup> "Review of the Moncton Shooting," p. 128.

1. "J" Division Occupational Health Services (OHS) staff and the RCMP National Occupational Health chief psychologist attended the hospital in Moncton to assist family members and arranged to bring in local resources, along with OHS staff from "B," "H," and "L" Divisions, and peer support personnel.
2. Staff Relations Representatives (SRRs) from "J," "H," and "L" Divisions were brought to Moncton to assist with the injured members and their families and the families of those who were killed.
3. Three members close to the fallen members were chosen to be family contacts, as provided for in the Fallen Members Guide.
4. Critical Incident Stress Management (CISM) trained mental health professionals and peer-support members assisted family members at the hospital.
5. "J" Division Health Services provided one-on-one counselling and a series of Critical Incident Stress Debriefings (a group support process) and "psychological first aid" to employees and families.
6. Once Mr. Bourque was captured, all members in Codiac were immediately given fourteen days' administrative leave.
7. Those who responded to the occurrence were able to prepare statements and complete notes without interference from regular duties, and members could receive immediate mental health care so they could heal and allow the detachment to become fully operational as quickly as possible.
8. A session was coordinated for the Codiac members, with a panel made up of retired police officers from the Moncton police shootings of 1974 and active members from Mayerthorpe and Hay River.<sup>299</sup>

Mr. MacNeil identified some issues regarding differential treatment and provision of insurance and services to members, civilian employees, and municipal employees involved in the incident. He said, "National direction is required to address how such processes will be managed in the future."<sup>300</sup>

Family members were upset with the delay in confirming the death of their loved ones. However, it took several hours for the OIC of Codiac Detachment to be able to confirm their identities, given the continuing search for Mr. Bourque and the fact that the crime scenes were off-limit to medical personnel and most members. The OIC did not wish to confirm any information until she had person contact with members at the scene. Mr. MacNeil said the family members understood this explanation.

### **Perpetrator Background, Threat Assessment, and Prior Opportunities for Intervention**

Mr. Bourque had had prior contact with police, but there were no intelligence holdings that indicated he was a potential danger to others. Mr. MacNeil noted that,

Members of his family knew that he had pointed firearms at family members, was in possession of a prohibited, over capacity rifle magazine, had committed violations of safe firearms storage and transportation laws and had heard reports of his careless firing of a

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<sup>299</sup> These detachments had also experienced the shooting deaths of their colleagues.

<sup>300</sup> "Review of the Moncton Shooting," p. 159.

gun at a bush party. Some of his friends were aware of some of these incidents as well. If any of these offences had been reported to police, there would have been an opportunity to launch an investigation which may well have led to the seizure of Bourque's legally acquired firearms, especially since his firearms licence expired on 2013-11-12.<sup>301</sup>

Mr. Bourque could not legally purchase or otherwise acquire ammunition due to his expired licence. A friend who had bought ammunition for Mr. Bourque on the day of the shooting likely knew that Mr. Bourque did not have a license, or he was willfully blind to that fact. It is illegal to knowingly give ammunition to someone who does not have a valid license. Mr. MacNeil suggested that amending the *Criminal Code* to require the presentation of a valid licence prior to the transfer of ammunition might deter such transfers or make it easier to prosecute them.

Mr. Bourque was known to the Moncton police prior to the June 2014 incident. A friend called police in 2009 to report that Mr. Bourque had expressed suicidal ideation. Codiac members interviewed Mr. Bourque and his parents, but did not substantiate the concern and closed the file. They made a notation in the Firearms Interest Police (FIP) database, as required, and a Firearms Officer followed up appropriately and confirmed that the safety concern was not substantiated. In 2010, Mr. Bourque was involved in a disturbance and said he was trying to retrieve a stolen wallet; two months later, a car he was in was stopped and he was given a ticket for open liquor. An empty ammunition box was found in the car. In 2013, his car was impounded after an accident, and the loss of the car apparently made him angry.

Mr. Bourque's Facebook account was not open to search engine queries, but his timeline, with posts about guns, gun control, violence, and anti-police sentiment, was visible to any Facebook user. Mr. MacNeil stated:

The prevention of crime is often seen solely as the responsibility of the police. Nothing could be further from the truth. The most obvious indications that Bourque might be a danger to society came from observations made by family, friends and acquaintances. Bourque had long been fascinated with firearms and had spent many hours at the range practicing his shooting skills. Recently, he continuously talked about firearms. Once Bourque was identified in media reports, calls were received from associates indicating he'd been expressing anti-authority/anti-police attitudes in recent years... Bourque's father reported similar such language in the days leading up to the shootings. During a conversation on either May 26 or June 2, Bourque told his father he'd had enough with the authorities and that he believed the police were corrupt. He stated he was no longer going to submit himself to the authorities and that the police would never take him to prison.

Others close to Bourque stated they were concerned about his state of mind... Many were aware of his firearms possession, and some knew that he possessed prohibited magazines. It was also reported after June 4 that Bourque had been alienated by some friends due to what they described as his unsafe handling of a firearm during a camping trip. The friends saw fit to stop inviting him to these outings, but took no further action. Bourque's father was concerned enough to have reached out to a retired military police officer for advice. Not one reported any of these concerns to a competent authority such as the RCMP or a health care professional. These were all opportunities to intervene early and would have at the very least prompted another FIP [Firearms Interest Police] review. This would have alerted authorities to the fact that Bourque's firearms licence had actually expired and would almost certainly have resulted in a proactive firearms prohibition.<sup>302</sup>

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<sup>301</sup> "Review of the Moncton Shooting," p. 132.

<sup>302</sup> "Review of the Moncton Shooting," p. 146.

Mr. MacNeil stressed the importance of providing mental health services to young people. He also emphasized the need for the public to understand the importance of helping people showing signs of mental illness, anti-authority/anti-social attitudes, or anger issues. “Although Bourque himself was not found to have been suffering from a mental illness, we cannot predict what motivating factors or underlying causes might be at the root of the next shooting of this nature... The key is that the public must be better educated and engaged, and mechanisms must be in place to allow for easy access to services.”<sup>303</sup>

Mr. MacNeil reviewed several programs in New Brunswick that are focused on community engagement, crime prevention, and youth mental health for youth and for adults, some of which include mental health screening. He concluded that had Mr. Bourque been referred to one of these services, they would have taken preventative action to address his anger and attitudes towards authority.

In the aftermath of these mass shootings, as in this case, investigations inevitably reveal that there were well intentioned individuals who had information that may have prevented the killings. We often hear that people “didn’t think he was serious” or that they “didn’t want to interfere.” There is often a tendency to avoid over-reacting for fear of someone being labelled.<sup>304</sup>

Mr. MacNeil went on to suggest that providing stigma-free mental health services can “assist in overcoming [the public’s] tendencies to ‘mind our own business’ by removing the labels often assigned to those who need help.”<sup>305</sup>

Mr. MacNeil briefly described the RCMP Behavioural Sciences Branch (BSB), which conducts threat assessments for people suspected of being on a pathway towards violence. The members of this branch examine various types of threats, including school violence, general violence, threats to police members, workplace violence, domestic violence, and criminal harassment. They use screening tools depending on the type of threat to assess the level of threat a suspect poses toward specific targets. They also suggest strategies and tactics on how to mitigate the threat. Mr. MacNeil stated that the capabilities of the BSB are not widely known and are under-utilized. He also made reference to a policy that requires that threats to RCMP members be referred to a Threat Evaluation Specialist.<sup>306</sup>

Mr. MacNeil discussed the characteristics of a “lone wolf,” as the term is used in the RCMP National Security program. He noted the ability of such individuals to inflict catastrophic harm without prior warning to law enforcement. He also noted that some “homegrown violent extremists” attack for revenge or notoriety rather than ideology. Because they can use commercial firearms or homemade explosive devices against low-security targets and rarely reveal their intentions in advance, they are much more difficult to detect and stop than traditional terrorist groups. Mr. MacNeil set out a list used within RCMP Federal Policing of potential indicators of lone-offender actions that may warrant reporting:

- a. Anti-government, anti-religion, racist or disruptive behaviours, apparent to those in close contact
- b. Use of extremist material such as books and internet forums and publications

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<sup>303</sup> “Review of the Moncton Shooting,” p. 149.

<sup>304</sup> “Review of the Moncton Shooting,” p. 150.

<sup>305</sup> “Review of the Moncton Shooting,” p. 150

<sup>306</sup> He did not identify this policy.

- c. Tendency to not work or socialize well with others; segregation from peer and family groups
- d. Posting of manifestos of extreme ideology
- e. Increased advocacy of violence toward society and government systems, which can lead to acceptance of the use of violence to make a point
- f. Acquisition of excessive quantities of weapons or explosive materials
- g. Persistent belief in righting a perceived injustice

Mr. Bourque did not exhibit all of these characteristics. He did exhibit anti-government and anti-police views. He was not part of any extremist group. He did not follow extremist social media but did follow right-wing American social media. He had difficulty holding a job but had contact with his family, had a network of friends, and was described as sociable. He posted heavy metal song lyrics and anti-gun control and anti-government propaganda on Facebook. He acquired his weapons long before he decided to attack police. He did see himself as fighting injustice. Mr. MacNeil concluded that there was no indication that Bourque was planning anything specific until late on the afternoon of 4 June.

Mr. MacNeil also noted that the National Security Enforcement Section did not find any evidence that Mr. Bourque was linked to extremist groups, so they did not investigate his attacks as acts of terrorism. Instead, the attacks were investigated by the New Brunswick RCMP as a multiple homicide. Mr. MacNeil suggested that police should examine perpetrators' political motivations and ideologies but did not make a specific recommendation on this issue.

### **Recommendations from Previous Reviews**

MacNeil considered the extent to which the RCMP had implemented the recommendations of reviews stemming from the murders of four RCMP members in Mayerthorpe, Alberta in 2005 (summarized above in section 5.1.) and the murder of two RCMP members in Spiritwood, Saskatchewan in 2006.<sup>307</sup> These reviews included fatality inquiries, Human Resources Skills Development Canada Investigations, Hazardous Occurrence Investigation Team (HOIT) reports, and Independent Officer Reviews. Mr. MacNeil noted:

Learning from tragedy has to be followed by effectively dealing with identified shortcomings. The Force has an obligation to take actions to protect its members, and it must act promptly to do so, not solely for statutory reasons but because of the moral contract it has with the members it sends into harm's way.<sup>308</sup>

Mr. MacNeil found that most of the policies implemented in response to the Spiritwood and Mayerthorpe incidents were followed during the incident in Moncton. However, he also identified the following problems:

1. It did not appear that the members responding to the Moncton incident had followed the National Policy guidelines for the securing of potential crime scenes, which had been amended following the Mayerthorpe tragedy.
2. The Spiritwood Labour Code investigation made reference to the need for protective equipment, and the Mayerthorpe HOIT report recommended that members be able to use a

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<sup>307</sup> The Mass Casualty Commission has issued a subpoena for copies of reports or reviews arising from the Spiritwood incident (subpoena dated 25 February 2022). No records have been received in response to this subpoena, as at 16 May 2022.

<sup>308</sup> "Review of the Moncton Shooting," p. 165.

higher level of ballistic protection when warranted. However, due to delays in procurement of hard body armour, members of the Codiac detachment had not been equipped with it.

3. Both the Spiritwood Independent Officer Review and the Mayerthorpe Review by Justice Pahl recommended changes to ensure RCMP members had firearms with appropriate capability to respond to high-risk events. Mr. MacNeil said, “Mayerthorpe and Spiritwood occurred against a backdrop of increasingly common active shooter incidents in North America and Europe. The RCMP-related incidents and the apparent trend towards more active shootings drew attention to the firearms capability gap that existed within the RCMP frontline and commenced a protracted process of studying, procuring and delivering the patrol carbine to members on the frontline.”<sup>309</sup> Although he recognized that compliance with procurement processes and justification for such costly items as carbines takes time, “the time it took to roll out the carbine project, including the training and delivery of the weapons to members of the RCMP, has taken too long.”<sup>310</sup>

The Spiritwood Canada Labour Code investigation found that bullet-resistant windows in RCMP vehicles could reduce injuries to officers and directed the RCMP to conduct a hazard assessment on this issue and take steps to prevent those hazards. Mr. MacNeil’s discussion of the RCMP research on this issue was redacted. He then noted that the National Use of Force unit had learned of new technology that could allow for bulletproofing of police vehicles. He did not make any recommendations on this issue.

The Spiritwood and Mayerthorpe reviews had made recommendations to address the inability of the system to locate members in vehicles. They had also recommended expanding radio coverage and encouraging members to practice shooting. Mr. MacNeil stated that the RCMP took the view that Mobile Work Station capability and training on communication with the OCC was sufficient to address the vehicle location issue. With respect to the other recommendations, Mr. MacNeil made an overall recommendation relating to the approval and procurement process relating to equipment affecting officer safety.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

- a. (Recommendation 1.1) It is recommended that additional training on lethal force over-watch be provided to members.
- b. (Recommendation 3.1) It is recommended that members be in possession of a cellular or satellite phone (where available) and police radio while on duty, as a required part of Service order #1.
- c. (Recommendation 3.2) It is recommended the RCMP examine how it trains frontline supervisors to exercise command and control during critical incidents.
- d. (Recommendation 3.3) It is recommended that the RCMP provide training to better prepare supervisors to manage and supervise throughout a critical incident until a CIC assumes command.
- e. (Recommendation 3.4) The RCMP explore options that would allow for a common operating picture (COP) to be available for simultaneous monitoring by frontline supervisors, Critical Incident Command, Division Emergency Operations Center (DEOC) and the National Operations Center (NOC). Such technology should have a mapping system capable of

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<sup>309</sup> “Review of the Moncton Shooting,” p. 172.

<sup>310</sup> “Review of the Moncton Shooting,” p. 173.

plotting resources, sharing information with other users and linking to operational dispatch systems that track police vehicle locations and individual officer movements .

- f. (Recommendation 3.5) That Emergency Management System and the web-mapping service from the NOC be considered for each Division and policy, training and supervision be established requiring their use in Critical Incidents, major events and disasters, by DEOC and the CIC.
- g. (Recommendation 3.6) It is recommended that, where it does not already exist, each Division establish a policy and protocol through an Emergency Operational Plan to identify entry/exit points and major transportation routes that should be alerted and monitored in the event of a relevant crisis.
- h. (Recommendation 4.1) It is recommended that when transporting TAVs long distances it should be done by rail or flatbed truck. (Recommendation 4.2) It is recommended that Geo-tracking technology for ERT be identified and introduced in a timely manner.
- i. (Recommendation 4.3) It is recommended that in low-light conditions all ERT members be equipped with night-vision devices and laser designators on their weapons.
- j. (Recommendation 4.4) It is recommended that annual night training exercises with Air Services be developed and undertaken to maintain proficiency for ERT members.
- k. (Recommendation 4.5) It is recommended that infrared (IR) strobes be attached to each TAV to enable them to be identified by specific callsign during operations with air surveillance.
- l. (Recommendation 4.6) It is recommended that non-ERT personnel be selected and trained as drivers for TAVs to free up ERT members for primary duties.
- m. (Recommendation 4.7) It is recommended that a standard list of equipment be developed for ERT duties and that this equipment be acquired and distributed across the program.
- n. (Recommendation 4.8) It is recommended in large scale events where Air Services is utilized, Air Services personnel with the appropriate training should be assigned to the Command Post as a liaison for air service support.
- o. (Recommendation 4.9) It is recommended that where possible, in ERT operations where aerial FLIR is used, Tactical Flight Officers be deployed as aircrew (refer to 7.12) .
- p. (Recommendation 5.1) Policy should be amended to state that where a general duty member is qualified in the use of a long barreled weapon and where one is available , the member must ensure the weapon is in the police vehicle while on duty.
- q. (Recommendation 5.2) Firearms must be stored with sufficient ammunition.
- r. (Recommendation 5.3) All RCMP members receive a briefing and demonstration on the appropriate deployment of HBA.
- s. (Recommendation 5.4) Shotguns should be fitted with slings to enhance their deployment and safety.
- t. (Recommendation 5.5) Maintenance and storage procedures of all detachment firearms and ammunition must be the subject of a mandatory ULQA.
- u. (Recommendation 5.6) During high-stress/high-risk incidents, a supervisor must clearly provide direction regarding equipment use.
- v. (Recommendation 6.1) It is recommended that trainers and supervisors take into account how cognitive biases undermine training and consider how to mitigate the effect of these natural and universal thought processes.

- w. (Recommendation 6.2) It is recommended that any testing component of RCMP firearms use include a physical exertion component as well as tactical repositioning and communication. This should be supplemented with practice, scenario-based, dynamic training and evolving risk assessment. They should include reminders of the firearms capability, even beyond qualification distances.
- x. (Recommendation 6.3) It is recommended that training material be made available concerning the difference between cover and concealment, including examples of the penetrative capabilities of bullets from various firearms.
- y. (Recommendation 6.4) It is recommended that IARD training be adapted to include various environments (not just schools/indoor) as well as decision-making, planning, communication, asset management, and supervision components to ensure members work through constant risk assessments and that OCC training in coordination/response to high-risk incidents should be conducted at the same time as IARD training to emphasize the realism of the scenario.
- z. (Recommendation 7.1) It is recommended that Codiac OCC consider the implementation of an automatic numeric identification (ANI) system to support officer safety.
- aa. (Recommendation 7.2) It is recommended that Codiac detachment radio coverage be examined outside of Moncton center to rectify areas that have gaps in coverage.
- bb. (Recommendation 7.3) It is recommended the RCMP examine the implementation of encrypted radio systems for operational effectiveness, officer safety, and protection of privacy.
- cc. (Recommendation 7.4) It is recommended that the two Moncton radio repeater sites be permanently patched to ensure members have optimum radio coverage while maintaining communication with the OCC.
- dd. (Recommendation 7.5) It is recommended that primary and secondary channels be examined in greater detail to allow dispatchers better control of network airtime.
- ee. (Recommendation 7.6) It is recommended that policy be developed that mandates the creation of a radio user guide which will be available to all members. This should incorporate a map of the province showing repeater sites/detachments and a list of the radio channels.
- ff. (Recommendation 7.7) It is recommended that a system be developed, both radio and data, that would allow for communication between RCMP members from the Maritime Divisions, when required to work outside of their home jurisdiction.
- gg. (Recommendation 7.8) It is recommended a high-resolution mapping system, such as the web-mapping service from the NOC, be integrated within CIIDS, having the ability to share vital information as perimeters and location data.
- hh. (Recommendation 7.9) It is recommended the RCMP research options for providing GPS tracking ability for members to ensure they can be located and tracked when dismounted from their vehicles.
- ii. (Recommendation 7.10) It is recommended that OCCs should have an experienced NCO available to coordinate operations in critical incidents and to offer direct operational advice to call takers and dispatchers.
- jj. (Recommendation 7.11) It is recommended the reporting structure of Codiac OCC is refined to ensure the Support Services Officer is engaged in the provision of training, equipment and policy considerations.
- kk. (Recommendation 7.12) It is recommended that ERT develop a quick reference guide for non-ERT trained members who may be called upon to offer assistance (e.g., aerial spotters and

other observation posts). These reference guides could be provided by the ERT telecommunications technician, who would be in a position to instruct members on ERT radio protocols.

- ll. (Recommendation 7.13) It is recommended the RCMP create policy that allows for the use of plain language as an alternative to 10-codes in urgent situations.
- mm. (Recommendation 8.1) It is recommended that NCS create a plan that can be referenced to allow relief for Division communications staff in the event of a prolonged incident. The plan should be developed to take into consideration the requirements of each Division.
- nn. (Recommendation 8.2) It is recommended that standard operating procedures be developed to ensure communications personnel are part of the initial operational callout procedure for serious events.
- oo. (Recommendation 8.3) It is recommended that news conferences in these types of incidents should have a spokesperson presenting the operational perspective of the investigation to reassure the community that police are taking action.
- pp. (Recommendation 8.4) It is recommended that software solutions be sought by NCS in order to properly monitor social media.
- qq. (Recommendation 8.5) It is recommended that up-to-date, functional, portable devices be provided to Communications personnel to enable them to effectively use social media and permit them to effectively do their job.
- rr. (Recommendation 8.6) It is recommended that NCS provide a point of contact with the essential skills for regimental funerals (internal or external to the RCMP) who is paired with the Strategic Communications Unit.
- ss. (Recommendation 8.7) It is recommended that all regimental funerals have a professional photographer to ensure they are properly recorded.
- tt. (Recommendation 8.8) It is recommended that families of fallen members be made aware that communications assistance is available to act as a buffer between the families and the media. In addition, this will provide families access to the RCMP website to post messages/photos.
- uu. (Recommendation 8.9) It is recommended that divisions have access to real-time social media monitoring, which could help identify operational risks and inform a communications strategy.
- vv. (Recommendation 9.1) It is recommended the RCMP develop an improved system to enable members to obtain ammunition for practice.
- ww. (Recommendation 9.2) It is recommended the relevant policies and practices should be reviewed to ensure there are appropriate controls and no constraints that would interfere with members improving their firearms proficiency.
- xx. (Recommendation 11.1) The Review recommends the RCMP consider broadening its support for initiatives that support young people with mental illness.
- yy. (Recommendation 12.1) Development of a national guide to establish roles and responsibilities and advice for managers and persons tasked with implementing an after care strategy. This could include a plan for rapid and scalable deployment, plus consideration for long-term maintenance to prepare for notable events such as the first year anniversary of the tragedy.
- zz. (Recommendation 12.2) Updating of the existing Fallen Member guide with considerations for the following: operational briefings of families, possible tour of the fallen members' work space

with the family, consideration for the management of flowers, cards and gifts, provision of information on the Depot Memorial and the Peace and Police Officer Memorial in Ottawa.

- aaa. (Recommendation 12.3) The critical incident stress management (CISM) team should consist of experienced psychologists who understand policing; experienced RCMP employee peer support personnel, RCMP chaplains and nurses trained in CISM.
- bbb. (Recommendation 12.4) Development of a plan for ongoing follow-up at specified periods during the first year and also during periodic health assessments (PHSs) for those members directly involved. Consideration should be given to the utilization of the questionnaire as noted in this section of the review.
- ccc. (Recommendation 12.5) A review of the processes related to the provision of aftercare services to those involved such as families, municipal employees, auxiliary constables, and volunteers should be undertaken.
- ddd. (Recommendation 12.6) Consideration should be given to ensuring that members who are unable to return to work are kept informed of information that could affect them.
- eee. (Recommendation 12.7) It is recommended that an interview with a psychologist should be conducted with employees prior to their return to duty to prepare them for changes in their work environment that have taken place as a result of a traumatic incident.
- fff. (Recommendation 12.8) A CISM team that was not involved with the operation should provide a Post-Action Staff Support (PASS) debriefing for those who conducted debriefings. This should occur once the operation is completed and preferably prior to their return to their home units.
- ggg. (Recommendation 12.9) When an employee is killed on duty, certain pay and compensation mechanisms are triggered that generate automated messages and mail to families relating to the cancelation of certain benefits. These automated processes lack sensitivity and cause undue stress. It is recommended a review of these systems be conducted to prevent this from occurring.
- hhh. (Recommendation 12.10) Following the death of a member of the RCMP, there is a substantial amount of required paperwork and procedural processes expected of family members. It is recommended that a liaison be identified to assist family members on behalf of the deceased with the completion of all necessary paperwork.
- iii. (Recommendation 12.11) When a member is physically/psychologically injured or deceased and thus unable to join appointments with their family, the spouses and children of the member cannot access the member's insurance and must rely on private insurance coverage. This coverage can only reimburse the cost of five to seven hours of psychological services per year. It is recommended that steps be taken to rectify this to remove the burden that this insufficient funding places on families of the members.
- jjj. (Recommendation 13.1) It is recommended the RCMP take immediate action to expedite deployment of patrol carbines across the Force. This action must include significant and permanent augmentation of the Force's training capacity.
- kkk. (Recommendation 13.2) It is recommended the RCMP conduct a thorough analysis of the approval and procurement processes (including the research and development phase) relating to equipment that impacts officer safety. This analysis should include identifying an appropriate senior authority to take responsibility for such projects, establishing appropriately resourced project teams, and setting deadlines for delivery.

#### 5.4. *R v The Royal Canadian Mounted Police (NB Provincial Court, 2017)*<sup>311</sup>

In September 2007, a judge of the Provincial Court of New Brunswick convicted the RCMP of an offence under the Canadian Labour Code for failing to protect its members during the Moncton shooting.

In her decision, Judge Leslie Jackson explained the history of police responses to active shooter incidents. Prior to the Columbine school shooting in the United States in 1999, the prevailing practice was for first responders to secure the scene and wait for specialized units, such as Emergency Response Teams (ERT), to engage the shooter. At Columbine, however, the perpetrators continued their rampage for 40 minutes before the SWAT team arrived. Police agencies then changed their practices. The RCMP developed its Immediate Action Rapid Deployment (IARD) policy in 2006–07, which required frontline general duty members to immediately respond to active threats.<sup>312</sup> The policies and training were geared toward active threat events in a confined setting, such as a school or shopping mall. IARD training beyond that provided to Cadets at Depot was not mandatory.

Judge Jackson reviewed the findings of reviews into the shootings of RCMP officers at Mayerthorpe and Spiritwood. She noted Associate Chief Judge Pahl's comments in the Mayerthorpe review (summarized above in section 5.1.) that the rollover from shotguns to patrol carbines should be given high priority.

At Spiritwood, a suspect who was being pursued by RCMP members killed two of the members with a high-powered rifle and shot at a third. The suspect then committed suicide. The internal RCMP review of this incident focused mainly on difficulties of extracting the members from the scene but concluded that the members at the scene followed the principles of the Incident Management Intervention Model (IMIM) and properly developed a plan in line with the resources and information they had. The Canada Labour Code investigation of the same incident,<sup>313</sup> however, concluded that the members did not follow IMIM, including the formal key risk assessment stages. The investigation directed the RCMP to ensure that its officers continue to receive instruction and training in the IMIM procedure. It also found that the members did not have adequate firearm capability or protective equipment and directed the RCMP to complete a hazard assessment of high-risk retrieval activities for officers when ERT is not available within a reasonable time. That assessment should include the types of firearms suspects may use, types of firearms available to officers, bullet-resistant equipment required for protection, and acceptable ERT response times in rural areas. These directives had a compliance date of 29 October 2007.

In response to these directives, the RCMP researched options for weapons for its members and then determined it needed more rigorous, independent research to justify any change to its use

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<sup>311</sup> *R v The Royal Canadian Mounted Police*, 2017 NBPC 6 (CanLII), <https://canlii.ca/t/hp75s>.

<sup>312</sup> An active threat was defined in the IARD policy as “one or more individuals who seek out an environment that offers multiple potential victims at risk of death or grievous bodily harm not easily able to escape the threat.” *R v The Royal Canadian Mounted Police*, 2017 NBPC 6, para 15.

<sup>313</sup> Under Part 2 of the Canada Labour Code, Health and Safety Officers appointed by the Minister of Labour may investigate workplace injuries in federally regulated workplaces and issue directives to the employer. See “Summary of Part II of the Canada Labour Code.” Government of Canada webpage (updated 14 March 2022), <https://www.canada.ca/en/employment-social-development/services/health-safety/reports/summary.html>. The investigation report is referred to in the reasons for judgment in *R v The Royal Canadian Mounted Police*.

of force approaches.<sup>314</sup> It took several years for the RCMP to identify a solution and approve the use of carbines for frontline members. The rollout of the first 375 carbines was approved in July 2012. Finally, in September 2013, “J” Division received their order of 22 carbines. They scheduled the first training course for general duty members for 2–6 June 2006 in Gagetown. The Moncton shooting incident took place on 4–6 June 2006; although there were in theory 22 carbines available to the first responders, they were all in use at the training course in Gagetown. The Hard Body Armour had also arrived at the Codiac Detachment, and members had been directed to familiarize themselves with it.

Judge Jackson found that the RCMP had breached section 124 of the Canada Labour Code, which provides that “Every employer shall ensure that the health and safety at work of every person employed by the employer is protected.” This requires employers to take all steps reasonably required to protect against risks employees may face in the course of their employment. Judge Jackson found that the RCMP failed to provide its members with appropriate use-of-force equipment, including patrol carbines and hard body armour, and failed to provide appropriate training to respond to an active shooting event, which amounted to a breach of s. 124. She found that RCMP management knew or should have known in 2007 or, at the latest, early 2011, that there was a “serious safety risk to frontline members when they faced heavily armed opponents and that this risk should be highly prioritized.”<sup>315</sup> Despite this risk, there were still serious delays in the rollout, including an almost two-year delay between the approval in July 2012 and the first training in Moncton in June 2014. Management appeared to be preoccupied with the cost of delivering training and other financial implications but were not concerned about officer safety. Judge Jackson found that although each individual step in the process of determining the appropriate weaponry to purchase, purchasing that weaponry, distributing and delivering it may have appeared reasonable, when taken as a whole, the length of time and lack of urgency in the RCMP approach established a *prima facie* breach of the duty of care required under s. 124 of the Code. She stated:

[I]t is beyond controversy that policing is a perilous occupation and sadly, as we know all too well, one in which danger of significant injury and/or death is present and can never be entirely eliminated. That does not mean that the risk should be ignored, nor does it mean that it must be accepted as being part of the job and therefore no efforts need to be made to reduce the frequency of risk or to mitigate the potential consequences of the risk or mitigate its occurrence.<sup>316</sup>

The RCMP argued that it had engaged in due diligence and asserted that although the risk presented by the lack of carbines was significant, the likelihood of events like Mayerthorpe and Spiritwood was relatively remote. Judge Jackson rejected that argument, holding that the fact that a risky event occurs infrequently does not mitigate that risk:

In the case of general duty officers now required to initially engage heavily armed suspects, there existed a grave potential of harm, although the likelihood of an incident in which death or grievous bodily harm actually occurred was statistically remote. While the RCMP could not control the causal elements in the sense of predicting or allowing the event to occur, there can be no question that they were aware of the increasing prevalence of heavily armed opponents and the presence of long guns particularly in the north and in rural areas.

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<sup>314</sup> Judge Jackson sets out the factors leading to this determination, which related for the most part on the findings of the RCMP Civilian Review and Complaints Commission report on the death of Robert Dzienkanski from a conducted energy weapon (Taser). See *R v The Royal Canadian Mounted Police*, paras 11–46.

<sup>315</sup> *R v The Royal Canadian Mounted Police*, para 75.

<sup>316</sup> *R v The Royal Canadian Mounted Police*, para 81.

The 2007 Needs Analysis for Hard Body Armor (Ex. 1, Tab 5) prepared by Bruce Stuart, notes at page 5 that “there has been an increase in the possession of firearms by criminals within Canada, in particular ‘high power’ weapons.” and later “anecdotally, RCMP members face rifle and shotgun threats regularly, especially in rural areas.” That same report at page 4 referenced a document prepared two years earlier which had recommended the provision of HBA as the appropriate required level of protection for general duty members and noted “In fact, it is felt that the risk in this area has increased, rather than diminished.” Yet on June 4, 2014, HBA had only recently arrived at Codiac Detachment and most of the responding members were unfamiliar with its use.<sup>317</sup>

Judge Jackson referred to “innumerable meetings... minutes of meetings and reports drafted and circulated, apparently to satisfy the requirements of the bureaucracy at RCMP Headquarters in Ottawa.”<sup>318</sup> She also noted that management was distracted at least in part by efforts to shield themselves from criticism. She noted that Alphonse MacNeil in his review of the Moncton shooting (summarized above in section 5.2.) had also concluded that the rollout took too long. The RCMP had also failed to put any mitigation strategy in place to protect frontline members responding to active shooters while the carbine project was in development. Problems with the lack of weapons qualifications were also known to RCMP senior management before the Moncton shootings: in January 2014, the RCMP Policy Health and Safety Committee informed the RCMP Commissioner that compliance rates for mandatory training for members were low. Nine of the 22 members who were first on the scene in Moncton had not requalified on their weapons.

Judge Jackson also rejected the RCMP argument that it needed to be cautious in equipping its members with carbines, given possible concerns about militarization of domestic police forces and the possible cultivation of a paramilitary culture among frontline officers.<sup>319</sup> She concluded that it was not reasonable to provide carbines to only 22 frontline members (which amounted to 3% of the frontline members in “J” Division) three years after they definitively concluded that an upgrade to existing weaponry was required to protect those members. She concluded:

Frontline officers were left exposed to potential grievous bodily harm and/or death while responding to active shooter events for years while the carbine rollout limped along, apparently on the assumption that as the likelihood of such an event was relatively rare, a timely implementation was not required. As Watson J said in *General Scrap Iron & Metals Ltd* 2002 ABQB 665 at paragraph 100:

“An approach which focused on likelihood of danger rather than on exclusion of danger where possible could encourage employers to engage in a chillingly brutal calculus of the odds of harm against the cost of its avoidance.”<sup>320</sup>

Several frontline officers who survived Bourque’s attack said at the time of the attack or at the trial that they were not able to engage Mr. Bourque because he had a long gun, and their guns were too short to be effective, given the range of their available weapons. One of them had had training in carbines while in the Armed Forces and believed that had he had a carbine, he could have effectively engaged Mr. Bourque. All of the RCMP managers who testified at the trial said the frontline members were adequately equipped to deal with the threat that Mr. Bourque posed to

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<sup>317</sup> *R v The Royal Canadian Mounted Police*, para 84.

<sup>318</sup> *R v The Royal Canadian Mounted Police*, para 90.

<sup>319</sup> *R v The Royal Canadian Mounted Police*, paras 101–4.

<sup>320</sup> *R v The Royal Canadian Mounted Police*, para 107.

them. Judge Jackson stated these managers “were all repeating ‘talking points’ designed to be the justification for their position.”<sup>321</sup>

The RCMP had been charged with two additional counts under s. 124 for failing to properly inform, instruct, or train the responding members to ensure their safety in an active shooter event in an open environment and for failing to properly inform, instruct, or train its supervisory personnel to enable them to ensure the health and safety of members during an active shooter event. Judge Jackson acquitted the RCMP of these two counts. She noted that the Crown had to prove that this training requirement was reasonable and that the hazard to be addressed by this training was actually or reasonably foreseeable. The RCMP argued that there was no evidence that anyone anticipated outdoor active shooter events. The judge rejected this, noting that Spiritwood in 2006 was in fact an outdoor active shooter event, and according to the MacNeil report, outdoor shooter incidents comprise approximately 10% of all North American active shooter events. She concluded that another such incident was foreseeable. She found that there was no specific training on outdoor active shooting events for frontline members or supervisors at the time of the Moncton shootings, in Canada or North America. Since Moncton and two open-area shootings in the United States, more departments were moving to train members on “exterior response skills.” However, the IARD training for recruits and the ongoing IARD training did provide the necessary skills for responding to outdoor shooting scenarios. Several members did use those tactics when responding to Mr. Bourque. As well, Judge Jackson did not find it reasonable to impose a requirement on the RCMP to provide training that did not yet exist.

With respect to training for supervisors, Judge Jackson found that although there was some confusion during and immediately following the shootings that could in part be attributed to a lack of training of supervisors, it was not reasonably foreseeable that “supervisors in a small city detachment would be faced with supervising the response to a killer who was actively seeking out and killing RCMP members.”<sup>322</sup> Therefore, training on such supervision could not be considered reasonably necessary. Again, the fact that such training did not exist was also relevant to her decision to acquit.

In her sentencing decision, Judge Jackson noted:

[W]hile the failure of most of the senior RCMP management team to acknowledge that there was any delay in the patrol carbine rollout is troublesome in regard to their apparent lack of insight into the importance of workplace safety, the response post-incident has been robust. The MacNeil Report was commissioned, prepared in a very short timeframe and, as of October 2017, 56 of the 64 recommendations have been implemented and/or concluded ... I cannot conclude, on the record, before me that the RCMP has failed to accept responsibility nor that a substantial likelihood of future offences has been shown.<sup>323</sup>

She ordered the RCMP to pay a fine of \$100,000 and ordered probation with conditions requiring the RCMP to contribute to memorial funds and trust funds for the children of the officers who died

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<sup>321</sup> *R v The Royal Canadian Mounted Police*, para 108.

<sup>322</sup> *R v The Royal Canadian Mounted Police*, para 118. Judge Jackson rejected the assertion by the RCMP that Mr. MacNeil’s recommendations for training for supervisors on managing critical incidents and inclusion of outdoor active shooter response tactics in IARD suggested he was applying a standard of perfection to the RCMP.

<sup>323</sup> *R v The Royal Canadian Mounted Police*, 2018 NBPC 1 (CanLII), <https://canlii.ca/t/hqzdi>, para 28.

in the Moncton shootings, along with other charities supporting families who have experienced workplace tragedies.

### 5.5. RCMP Security Posture: Parliament Hill, October 22, 2014 (Ontario Provincial Police, 2015)<sup>324</sup>

Following the 2014 shooting on Parliament Hill by Michael Zehaf-Bibeau, the RCMP asked the Ontario Provincial Police (OPP) to review the RCMP's actions, specifically the RCMP's security posture on the grounds of Parliament Hill at the time of the incident, including compliance with standard operating procedures, and the RCMP's initial incident response, including actions of RCMP officers, operational communications, and compliance with the Operational Preparedness Plan. The OPP team who conducted the review visited the grounds of Parliament Hill and the RCMP Operational Command Centre. They also interviewed RCMP officers, directors of security on Parliament Hill, Ottawa Police Service Incident Commanders who were involved in the incident, federal employees from Parliament Hill, and a retired House of Commons clerk. They also reviewed previous reports and recommendations on Parliament Hill Security matters.

Responsibility for the protection of Parliament Hill is shared between the RCMP (responsible for the security of the grounds of Parliament Hill) and the House of Commons Security Service and Senate Protective Services (responsible for security inside the buildings). Ottawa Police Services is responsible for responding to crimes on Parliament Hill and for the area surrounding Parliament Hill. The Report is heavily redacted. However, the report writers made the following findings:

- a. Mr. Zehaf-Bibeau fatally shot Corporal Nathan Cirillo, who was standing in ceremonial guard at the Canadian National War Memorial. The Memorial is located at the intersection of Wellington Street and Elgin Street, east of Parliament Hill. Mr. Zehaf-Bibeau then drove west on Wellington Street, abandoned his car on Wellington just outside the East Block gates of Parliament Hill, and entered the grounds through the pedestrian access at these gates. He ran to a car parked near the East Block, forced the driver (a Member of Parliament) out of the car, and drove up to Centre Block. He entered Centre Block with a long gun in his hands and went through the main doors. Several RCMP officers who were on duty on Parliament Hill saw the gunman on his way to Centre Block but were unable to stop him before he entered. Several officers hesitated to enter the building because of directives to never enter the building armed. Once the Shift NCO arrived, he ordered the officers to enter. They did so and assisted in eliminating the threat. Several reports of other gunman sightings in the vicinity followed. Various agencies responded, police command centres were set up, and lockdowns were put in place while police searched for other suspects. Eventually, police confirmed that there was only one gunman involved, the Parliament buildings were cleared, and the lockdown was lifted.

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<sup>324</sup> "RCMP Security Posture, Parliament Hill, October 22, 2014: Ontario Provincial Police Review and Recommendations," Royal Canadian Mounted Police (March 2015), <https://www.rcmp-grc.gc.ca/en/rcmp-security-posture-parliament-hill-october-22-2014>. Note that although the redacted version of this report is available on the RCMP website, the PDF version contains a footer stating that the report is "not to be used in affidavits, court proceedings or subpoenas or for any legal or judicial purpose without consent of the originator," and the report's contents are not to be reproduced in whole or in part without consent of the originator.

- b. The OPP Report was not critical of the officers' responses and actions and noted that they had not received any mandated training to address threats such as this. The Report also identified issues with Incident Command and Control; this discussion was redacted.
- c. The approach to the security and protection of Parliament Hill was highly inadequate. The security framework for Parliament Hill makes it extremely difficult for all three agencies to provide proper service, making this area vulnerable and difficult to protect. The vast majority of security resources are stationed inside the buildings. (Further details are redacted.) The security posture on Parliament Hill the day of the incident was consistent with the procedures set out in the Parliament Hill Security Unit Standard Operating Procedures. However, the response was limited because of pre-existing deficiencies in training, pre-incident planning, and equipment. A "great number" of these deficiencies were identified in prior reports on video surveillance, perimeter pedestrian screening, and a proposal for a Parliamentary Precinct Security Force. The OPP Report found that the RCMP was not prepared to deal with this type of threat due to lack of planning, training, and resources.
- d. There is no radio interoperability between the RCMP and other police agencies; all communications with multi-jurisdictional partners take place over the OCC phone system. This lack of communication interoperability was a "major issue" during the incident. Members of the three agencies responsible for security were unable to communicate with each other directly, which delayed the effective relaying of information and prevented the efficient deployment of resources. The OCC was also short-staffed, which affected their operations.
- e. The Report identified issues with training of officers assigned to Parliament Hill and with joint training with other agencies such as the Ottawa Police Service and other emergency responders. (The details are redacted.) The Report also noted that the RCMP officers on Parliament Hill need access to a long gun with multipurpose capability.
- f. Budget cuts in 2012 limited the resources available for the RCMP posture on Parliament Hill. The resources have had to be maintained through reliance on reservists and overtime to meet required staffing levels. The RCMP's threat assessment of Parliament Hill was changed in January 2013 (presumably increased, but this information is redacted), but no additional resources were assigned. RCMP officers often request a transfer to Parliament Hill when they want to return to Ottawa. It is considered an inferior posting because it is perceived as a "security guard" position. Specific training and support would improve working conditions and make postings to Parliament Hill sought after.
- g. Only plainclothes officers of the House of Commons Security Service are armed. There is unlimited pedestrian access to the grounds through openings in the fence, and the fence only prevents vehicles from entering. (Parliamentarians and employees driving onto the grounds go through a Vehicle Screening Facility next to West Block.) Members of the public are able to walk to Centre Block, go into the building and through the visitor's area before they are asked to identify themselves, have their bags searched, and go through a metal detector. The Report also identified the fact that the gunman's access to a parliamentarian's vehicle clearly limited officers' ability to intercept him.
- h. The Report made reference to previous public complaints, the need to maintain the concept of "open public access," and the historic refusal to limit access by parliamentarians to the grounds, but the discussion on these issues is redacted. The Report made findings and recommendations on "outdated and lack of security equipment," evacuation plans, and airspace monitoring, which are redacted. The ongoing construction

on Parliament Hill, which was expected to last another 15–25 years, creates challenges for providing proper security.

- i. The working relationship between the House of Commons Security Service, the Senate Protective Service and the RCMP is inadequate. They work separately with limited information-sharing and only interact during meetings of the Master Security Plan Committee. These three agencies use different communications systems with no interoperability, have separate training with no formal joint training exercises, and limited interactions between their members. The Report described them as operating in silos. Officers from each agency are unfamiliar with each other. Numerous reports have recommended a unified security force on Parliament Hill, which has led the three agencies to focus on self-preservation and fostered an “us-against-them” attitude. They are quick to find fault with each other instead of working together to provide a superior service. Following the incident, the House of Commons Security Service and Senate Protective Services announced that they would unify their services to have one service for Parliament building interiors. They also announced that their officers would be equipped and trained to carry firearms. The following year, the federal government announced that the RCMP would take over operational command of all security on Parliament Hill, including security oversight and the command of interior building security. The OPP review Report identified this unification as the most important change required to improve security on Parliament Hill and noted that it had been recommended in numerous other reviews.
- j. The relationship between the RCMP and Ottawa Police Service is excellent, with good cooperation and exchange of information between them. However, there is no consistency in calls for service to the OPS on Parliament Hill. The Review noted that OPS should be made part of the Master Security Plan Committee and should participate in training exercises with the Parliament Hill security agencies.
- k. The Report noted three earlier attacks at Parliament Hill that demonstrated how vulnerable the area is to attacks. It also identified six earlier reports regarding Parliament Hill security that made consistent recommendations in several areas, including interoperability with other services, tactics and training, staffing, and communications. The Report concluded as follows:

The unfortunate incidents of October 22, 2014 at the Cenotaph and Parliament Hill are a grim reminder that Canada is ill-prepared to prevent and respond to such attacks.

Fortunately, the attacker was unorganized. The end results could have been much worse with the likelihood of many more casualties.... There have been other terrorist related incidents and in Canada since October 22, 2014, that are indicators that similar attacks are possible and probable.<sup>325</sup>

- l. Historical and political influences (which are not named in the Report) have led to a resistance to changes in security recommendations made in past reports, reviews, and audits. The Report stated:

There have been numerous reviews and reports previously authorized by the RCMP, the Office of the Auditor General, Parliamentarians, other departments and individuals focusing on the Security of Parliament Hill. All of these reports have resulted in numerous recommendations similar to those proposed in this review. Unfortunately, few of these recommendations have been implemented... The escalation of terrorism threats and the ability for these terrorists to successfully utilize new technology support the need for updating security measures on Parliament Hill... Parliament Hill is a symbol

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<sup>325</sup> “RCMP Security Posture,” p. 29.

of Canadian democracy. If Canada is to remain vigilant and proactive in dealing with threats directed to this country, there has to be a willingness to implement changes to protect this area.<sup>326</sup>

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 23) Radio interoperability between police services in North America is an officer and public safety issue and has become the standard for multi-jurisdictional police operations. Radio interoperability allows one police service the ability to patch their radio system with another police service's radio system and conduct a joint operation where communications usually play a key role. This allows, when required, one police service to contact the other service by telephone and request & initiate radio interoperability. The patching of two talk groups would occur rapidly allowing two way radio communications to exist between both police services controlled by the dispatcher(s). Memorandums of Understandings should be in place with weekly testing of the system performed between the two agencies. Plain language should be used and not the traditional ten codes. Interoperability has proved invaluable during multi jurisdictional police responses for such events.
2. (Recommendation 60) The RCMP needs to provide training to its supervisors with respect to site management and control during a critical incident. The supervisor needs the ability to coordinate and direct resources to mitigate any situation.
3. (Recommendation 61) The RCMP should develop SOP's to have a trained Critical Incident Commander immediately attend the site and assume control of the incident from the site supervisor.
4. (Recommendation 63) Officers involved in a critical incident such as the incident on October 22, 2014, should be relieved and provided access to proper support and professional assistance at the earliest opportunity.
5. (Recommendation 66) Interagency debriefs must occur to identify gaps or issues with the developed plans.

### **5.6. External Engagement and Coordination: Parliament Hill Incident After-Action Review (RCMP National Division Review Team, 2015)<sup>327</sup>**

After the incident on Parliament Hill in October 2014 and in addition to the security posture report prepared by the OPP (summarized above in section 5.4.), the RCMP National Division also conducted an “after action” review, focused on the external coordination and engagement of partners and the protective actions taken by the RCMP on the grounds of Parliament Hill. This review did not examine any pre-incident knowledge of the perpetrator or resourcing of the partner

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<sup>326</sup> “RCMP Security Posture,” p. 10–11.

<sup>327</sup> “External Engagement and Coordination: Parliament Hill Incident on October 22nd, 2014 – After-action Review” RCMP National Division Review Team (29 April 2015), <https://www.rcmp-grc.gc.ca/en/external-engagement-and-coordination-parliament-hill-incident-october-22nd-2014-after-action-review>. Although the Report is available on the RCMP website, the publicly available version contains the following note: “Throughout the document \*\*\*\*\* denotes where content was redacted as per the Access to Information Act and Privacy Act. Due to the content redactions, the report was reformatted and therefore differs from the original version submitted to the RCMP.” The Mass Casualty Commission issued a subpoena to the RCMP on 25 February 2022 for two reports associated with the RCMP response to this incident. As of 16 May 2022, the Mass Casualty Commission has not yet received these records.

agencies. (A separate OPP review investigated the shooting of Michael Zehaf-Bibeau and concluded it was justified.) The National Division worked with representatives from the RCMP Internal Audit, Evaluation and Review Branch to conduct the review, using interviews, questionnaires, video and other evidence from the incident, and a focus group with external partners and RCMP members. The draft report and recommendations were circulated to the partners prior to finalization of the report.

The Report described Operational Plans as “predefined courses of action that culminate into an overall response that is believed to have the highest probability of achieving success, relative to an organization’s strategic and tactical goals and objectives.”<sup>328</sup> It noted the importance of Emergency Operational Plans (EOPS):

In crisis situations, organizations shift into a reactive mode, and the likelihood of communication breakdowns increase. An EOP strives to alleviate the potential impact of communication breakdowns on operational responses by:

- a. Assigning responsibility to organizations and individuals for carrying out specific actions at specific times and places relative to a specific situation;
- b. Clearly defining governance structures (authorities and organizational structures);
- c. Detailing how resources (human, financial and capital) will be protected during an emergency;
- d. Identifying the resources available for use during the response to an emergency situation; and
- e. Articulating mitigation strategies that are acceptable in responding to an emergency situation.<sup>329</sup>

The Review identified the following issues with respect to the external engagement and coordination of the events of 22 October 2014:

1. There had been almost no joint training between law enforcement and security service providers within the Parliamentary Precinct prior to the events. The review stated that all first responders in a multi-jurisdictional environment should be familiar with the various operational approaches of their partner organizations. They should also have a pre-established approach to responding to a critical incident. The review identified the success of the RCMP ERT and Ottawa Police ERT in securing and evaluating the buildings during the event as evidence of the value of joint training.
2. The Report noted issues with respect to the ability of first responders to deliver urgent trauma care in critical incidents. It identifies that “life or death can be directly attributed to the first responder’s ability to provide life saving techniques and strategies to trauma victims.”
3. The Report also identified problems with the evacuation of the grounds of Parliament Hill and confusion around access and evacuation routes. It noted that in a crisis, the greatest risk of injury arises from the efforts of a mass of people trying to leave a contained area. (Further details of this discussion are redacted.) The Report also identified issues with vehicle traffic on Parliament Hill, the availability of up-to-date floor plans, surge capacity and operational readiness, and the capacity of the National Capital Region Command

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<sup>328</sup> “External Engagement and Coordination,” p. 8.

<sup>329</sup> “External Engagement and Coordination,” p. 8.

Centre (NCRCC) to sustain 24/7 operations for long periods (the details of which are redacted).

4. The Review considered the decision-making process and governance structure at the time of the events. It found that the overall decision-making was effective because of the existing relationships and coordination between the RCMP, the House of Commons Security Service, and the Senate Protective Service. However, it identified the fact that the governance and accountability for these agencies operate in silos as potentially impeding the implementation of the recommendations in the review and other reviews, as well as limiting operational and administrative efficiency.
5. The NCRCC is a permanent facility responsible for the direction, control, coordination, and support of incidents or major events in the National Capital Region and operates as the NCR's Emergency Operations Centre. It operates under the direction of the National Division's Officer in Charge (OIC) of Criminal and Protective Operations. It includes representatives from all partner agencies and is activated in crises situations that constitute threats to the security of Canada. It houses the Communications Centre for the event, monitors equipment and personnel requirements, acquires, analyses, and disseminates intelligence, and records key response activities, including emergency notifications, major response actions, evacuations, and responder casualties. The NCRCC was activated during the October 22, 2014 incident. The After-action Review found that there were significant concerns regarding the structure within the NCRCC. The Incident Commanders received conflicting information, which complicated the decision-making process and impeded the NCRCC's ability to fulfill its mandate effectively. As well, no investigative information was communicated to the NCRCC during the incident, which affected its ability to make informed decisions aligning tactical responses with investigations. Although the recommendation on this issue was redacted, the Review noted that as a result of the Moncton incident, Air Services was engaged at the onset of NCRCC or Division Emergency Operations Centres, which was well received.
6. Further discussion of the use of Air Services was redacted, except for a reference to an onsite resource having provided necessary information surrounding the regulation of the aviation industry and providing a direct link to aviation resource requirements.
7. The Review described the Incident Command System, which had been proven and highly refined over the previous years and followed by the RCMP and the Ottawa Police Service. It noted that there are two different training mechanisms for critical incident command: the Critical Incident Commanders Course is taught at the Canadian Police College and available to any law enforcement member who will be responsible for leading and commanding a critical incident, while the Incident Commanders Course is taught at the Justice Institute of British Columbia and available to any individual who would be responsible for leading, managing or commanding a critical incident. The Review stated the following regarding critical incident responses:

Critical incidents require special organizational skills and abilities on the part of responders managing personnel in order to attain a successful outcome. These special skills make it essential that all first responders (with[in] a jurisdiction) have consistent and appropriate training in order to ensure the seamless management of crisis situations. Having a common understanding and approach to a wide range of crisis and critical-incident intervention strategies, will ensure that all responders within a specific jurisdiction are able to manage and control a complex critical-incident environment.<sup>330</sup>

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<sup>330</sup> "External Engagement and Coordination," p. 13.

8. The Report also identified a lack of clarity regarding which organization had authority to issue and lift the lockdowns placed on government buildings in the downtown core of Ottawa, regarding whether this incident should be investigated as a criminal matter by the Ottawa Police Service, or by the RCMP as a national security matter. The incident also raised issues with respect to the RCMP's mandate to protect the Prime Minister.
9. All of National Division's operational and administrative resources were deployed to respond to the incident. Employees from National Headquarters filled the gaps left by this deployment, but poor coordination and inconsistent messaging between National Division and National Headquarters caused confusion and frustration among employees.
10. A significant portion of the Report focused on communication issues. The review stated:  
 Inefficient and ineffective operational communications during a critical incident will not only result in a breakdown in operational responses but create undue frustration and confusion amongst stakeholders, negatively impact the reputation of all organizations involved, and increase the length of time for complete resolution of a critical incident.<sup>331</sup>
11. The Report identified the following problems with operational communications during the incident:
  - a. Interoperability of communication technology, which created unnecessary delays in creating situational awareness. An example was given of the initial 911 call.
  - b. Communication centres in makeshift/secondary command posts, which were intended to provide a centralized point of coordination for all tactical responders as well as act as the communications bridge between the NCRCC and frontline responders;
  - c. Integration of member-to-member communication during the incident;
  - d. Lack of a standardized radio protocol;
  - e. Inability to communicate with people locked down in the Parliamentary Precinct buildings; and
  - f. Delays in providing key partners and potential responders with situational awareness.
12. The Report also identified issues regarding external communications during the incident:
  - a. Representatives from National Communications were sent to assist the National Division communications team during the first press conference held at National Division. However, the National Division communications team was not part of the coordination process, which led to failures to meet the National Division communication standards in the use of social media, translation, and logistics. The Review identified as a best practice the fact that National Division Communications was in constant communication with the Communications and Media Relations Unit at the Ottawa Police Services, which led to joint press releases and coordinated and consistent messaging.
  - b. Occupants locked down within the Parliamentary Precinct were sharing information, including operational movements and situational details, via social media, telephone interviews, and other media sources. (The details of this discussion are redacted.)
  - c. Various representatives from National Communications at Headquarters placed pressure on the National Division communications representative in the NCRCC, and there were problems providing the Communications lead in the NCR with timely information on operational decisions that would result in an increase in media requests. The Review identified as a best practice the use of Twitter to issue warnings

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<sup>331</sup> "External Engagement and Coordination," p. 14.

to people in the downtown core to stay away from rooftops and windows, to advise the public of the status of the situation, and to support the ongoing investigation. The Report referred to the successful use of Twitter during the Moncton incident and said “Moving forward, it is essential that the best practice of leveraging social media as a vehicle for all communications (i.e., during a critical incident and as a means to increase public awareness) ... be continued.”<sup>332</sup>

The Report concluded by noting that although there were gaps and unacceptable levels of risk requiring recommendations for improvement, the organizations involved worked together to ensure the safe resolution of the incident and were courageous in their operational response.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 1) It is recommended that mandatory Joint scenario based training, that includes a mix of table top exercises and operational training exercises, between all first responders (RCMP, OPS, Parliamentary Security, SQ Gatineau Police, OPP, EMS) within the National Capital Region be continued and expanded upon on an annual basis (at a minimum) to enhance tactical familiarity, establish trust, which will foster efficient and effective operational interactions and responses to incidents within the Parliamentary Precinct.
2. (Recommendation 16) It is recommended that make shift command posts have the capacity to provide communication centres for all first responders during a critical incident/emergency, including ERT and Ottawa EMS.
3. (Recommendation 17) It is recommended that a cross-jurisdictional working group be established to examine the issue of integrated operational communications during a critical incident and/or emergency situation. The feasibility of solutions like primary and secondary radio channels should be examined. The mutual aid channels would enable all first responders to communicate with each other as required. The primary channel would be dedicated for critical incident/emergency communications and the secondary channel would be reserved for non-urgent communications.
4. (Recommendation 22A) It is recommended that any and all communications relating to a critical incident that is unfolding in a Division be led by the Division's communication lead. Coordination between National Headquarters and the Divisional leads should align with established communication protocols that clearly define the roles and responsibilities surrounding communications during a critical incident. In the event that these communication protocols don't exist, it is recommended that they be developed, formalized and implemented.

## **6. GENDER-BASED AND INTIMATE PARTNER VIOLENCE**

The Order in Council directs the Mass Casualty Commission to examine “contributing and contextual factors, including the role of gender-based and intimate partner violence” ((b)(i)) and “police policies, procedures and training in respect of gender-based and intimate partner violence” ((b)(iv)). Media reports suggest that members of the community may have reported concerns about assaults by the perpetrator against his partner years prior to the events of April 2020 and may likewise have reported that he had a cache of illegal firearms. Other media reports suggest that past behaviour of the perpetrator towards one neighbour may fit the definition of gender-

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<sup>332</sup> “External Engagement and Coordination,” p. 18.

based violence (criminal harassment). The events of April 2020 reportedly started when the perpetrator restrained and attacked his common-law spouse.

The Mass Casualty Commission research and policy team has adopted the following deliberately expansive working definitions of gender-based and intimate partner violence in order to identify potentially relevant reports for this environmental scan:

Gender-based violence is defined as any violence (including threats, harassment, coercion, or other conduct that instills fear in the target of the behaviour), where that behaviour may have a gendered basis or component.

Intimate partner violence is defined as any violence (including threats, harassment, coercion, or other conduct that instills fear in the target of the behaviour), where the target of that behaviour is or has been in an intimate partner relationship with the perpetrator of the violence. Intimate partner violence may be mutual violence – i.e., it may be violence committed by two parties who are within an intimate relationship, against one another.

## 6.1. Nova Scotia

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### 6.1.1. Changing Perspectives: A Case Study of Intimate Partner Homicide in Nova Scotia (Health Canada, 1995)<sup>333</sup>

Following the murders of a number of women in Nova Scotia and elsewhere in Canada, the Family Violence Prevention Division of Health Canada commissioned Peggy Mahon from St. Francis Xavier University to conduct a study, which was released in February 1995. The study identified the factors involved in intimate partner homicides and made recommendations to improve government and community responses to escalating spousal violence. Ms. Mahon reviewed seventeen intimate partner homicides from the previous five years, using qualitative methodology. The specific methodology used is not explained in the excerpts available to the Commission, but the author states that she examined the dynamics of the relationships leading to the homicides and determined the history of contacts made by both partners in each case with the criminal justice system, health care system, child protection agencies, community supports such as family members and friends, shelters, churches and workplaces.

Eleven of the seventeen cases had male perpetrators who killed their female partners or ex-partners; six had female perpetrators who killed their male partners or ex-partners. (The author noted that these ratios are not the norm and that there were no known same-sex intimate partner homicides during the study period.) Two of the cases were Black couples, and the remainder were white. The relationships ranged in duration from four months to 24 years.

Ms. Mahon made the following findings regarding the dynamics of the intimate partner relationships:

- a. Most of the relationships started as “normal” relationships in the eyes of the couple.

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<sup>333</sup> “Changing Perspectives: A Case Study of Intimate Partner Homicide in Nova Scotia,” Family Violence Prevention Division of Health Canada (February 1995). The Mass Casualty Commission requested this report through a subpoena to the Government of Nova Scotia. Only the report’s Executive Summary and Chapter 9 (Recommendations) were provided in response to the subpoena. This summary is drawn from these excerpts.

- b. Male possessiveness or ownership over the woman was a common factor, as was emotional dependency by the men on the women.
- c. In each case, there was a “turning point” that led to an escalation of control, violence and, ultimately, the homicide. In fifteen of the cases, the turning point involved the man’s perception of the woman’s behaviour (such as real or imagined affairs, efforts to gain economic independence, challenging the man’s control or potentially leaving) as threatening to the status of the relationship. In the two other cases, the woman perceived the man’s behaviour (such as real or imagined affairs or potentially leaving) as threatening to the status of the relationship and confronted the man, who in turn escalated the control and violence. The key element in all the cases was the potential or actual loss of the relationship, and the man’s belief that he owned the woman and had the right to keep her in the relationship.
- d. The escalation in violence leading to the homicides involved economic control, physical and sexual violence, and psychological terrorism. This included threats of murder and suicide, stalking, forced isolation, use of weapons, and using the children. Prior to the turning point, the women had managed the violence. Following the turning point, the women tried to resist the increased control, protect the children, and escape. They often returned. They became exhausted and worn out.
- e. The men denied the violence, blamed their partners for the violence they inflicted, developed problems with their employment, and their health deteriorated, including their emotional health. They became agitated, anxious, and exhibited erratic or unusual behaviour. Male abuse of alcohol intensified the violence. The eleven men who killed their partners became obsessed or fixated over the partner’s alleged affairs or career, or about getting the partner to return to the relationship. They refused to believe the relationship was over. Eight of the eleven men attempted or committed suicide.
- f. The women who killed their male partners were in relationships in which the male partner inflicted severe physical violence upon them. Both partners in these relationships tended to abuse alcohol and were frequently intoxicated. The women were violent with the men and used weapons during the period of escalation. They had experienced trauma from violence in their past and in their current relationships and felt desperate and trapped. They believed they were unable to escape the violence due to poverty, fear of potential homelessness, and fear of the partner.
- g. There were what the author referred to as “observable indicators” of the turning point and escalation of violence, noticed by friends, family members, and neighbours, as well as by service providers.
- h. Over half of the couples shared the following points of contact with service providers: police, family doctor, hospital Emergency Room, municipal social services, workplace, and families. Some couples had contact only with their workplaces and their children’s schools. The author described these points of contact as significant because they are common opportunities for intervention. The family doctor, in particular, was the most frequent point of contact and, because of their role as a referral source, was in contact with the most other service providers. Probation was another common contact point for abusive men.
- i. The Report analyzed the reasons for these contacts, which the author described as “presenting problems.” The women sought help from a variety of service providers for problems associated with the violence, including personal safety, housing, economic issues, health, emotional support, and protection of their children. Almost all of the women had economic issues, frequent moves, evictions for “disturbances,” and many presented

with mental health problems. The women were more likely to voluntarily disclose the violence to family, friends, clergy, people in the workplace, and staff at women's shelters than they were to government agencies.

- j. Many of the children also demonstrated behaviour problems such as sleeplessness, hyperactivity, and conduct problems at school and in the community.
- k. The men also sought assistance for emotional support, housing, economic or health problems. Some men were unable to go to their parents' home upon the end of the relationship because they had experienced abuse as a child or had been abandoned. Five of the men who had left the family home or been removed by police had nowhere to go and were virtually homeless. Thirteen men had significant problems with employment during the period leading to the homicide. Men were most likely to seek emotional support from family members, friends, or members of the clergy. A third of the men had health problems, including depression, suicidal tendencies, and anxiety. Five of the men were being treated for mental health issues in the two years before the homicides. All of them had acute anxiety, depression, and suicidal thinking. Two had told their therapist or doctor of homicidal-suicidal thinking or that they had attempted to kill their partners and themselves.
- l. The women who became violent primarily did so when they experienced an escalation in violence by their male partners. The Report found that "it was the men in these cases who repeatedly beat the woman, who sexually assaulted the women," who tried to prevent them from working or accepting promotions, who beat them over suspected affairs, and who relentlessly stalked the women when they tried to leave the relationship. The Report also noted that these men used ropes, knives, forced isolation, threats to kill, suicide pacts, and attempted homicide and homicide-suicide plans before the women killed them.

The Report identified the following issues with government agencies and community supports:

- a. The "failure to identify and link the violence or patterns of violence in the relationships to the presenting problems."<sup>334</sup> The author identified this as the most critical issue in service response. This was caused by a lack of mechanisms to systematically document patterns of violence and communicate those patterns through the system. As well, the limited mandates of service providers other than police to identify and record patterns of violence led them to fail to ask questions about the relationships and violence.

Nine of the couples were involved with the criminal justice system before the homicides. Ms. Mahon made the following observations:

There were severe problems with the lack of mechanisms to identify the patterns of violence and to link the patterns to the presenting problems and to appropriate charges. There were also problems with lack of mechanisms to document the patterns of violence. Therefore, the police, Crown prosecutor, the courts, and probation officers were not able to recognize, understand and communicate the patterns of violence, (such as stalking behaviour and indicators of an intimate partner homicide-suicide plan) from one component of the system to the other.

Most of the presenting problems the police responded to in these cases were directly linked to physical assaults, psychological terrorism involving threats to kill, use of weapons, stalking, forced isolation and to homicide-suicide plans. The police, however, were responding incident by incident. When taken incident by incident, a number of the presenting problems were primarily summary offences,

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<sup>334</sup> "Changing Perspectives," Executive summary, p. xvi.

such as property damage, intoxication in a public place, causing a disturbance, and mischief. The resulting charges were neither linked to the women nor to violent behaviour. What happened then was a chain reaction through the criminal justice system. Because the charges were not linked to the pattern of violence, and because there is no way, at present, for the police to systematically link each incident to the patterns of violence, the information to the Crown was not documented in a way to understand it as a pattern of violence or an indicator of a very serious situation, such as a homicide-suicide plan. The Crown and the court then did not prosecute or sentence in a way to reflect the seriousness of the situation, results were that the court did not treat men as violent offenders, did not hold some men on remand to a bail hearing and sentenced lightly.

In many situations the police had a great deal of information, but they had no mechanisms to systematically document the information. Information was documented as separate incidents, documented in different locations within their information systems, or not documented.<sup>335</sup>

- b. Failure to recognize the degree of danger when violence was identified; and failure to take the situation seriously:

The police did not treat some situations seriously. They did not tend to lay charges in the known reported assaults and did not link the threats to kill or suicide threats to patterns of stalking behaviour or forced isolation. In a number of cases the police stopped laying charges, stopped responding, did not investigate thoroughly or did not respond. The individual's demeanour, how they were known, a history of not showing to testify, substance abuse, and focusing on another theory, influenced their response. The police became frustrated and de-sensitized in repeat cases involving alcohol.<sup>336</sup>

- c. Lack of or poor documentation; and lack of or poor communication within a system or between various systems: "Neighbouring police forces, which were dealing with the same situation, did not communicate with each other. This resulted in fragmented information on past history of offences and contact with police and, therefore, poor response by police."<sup>337</sup>
- d. Overloaded systems, including high caseloads, lack of resources, and long waiting periods. This in turn led police, probation officers, income assistance, and child protection workers to focus only on the highly visible issues. The presence of substance abuse in particular tended to draw attention away from all other issues. A number of the people in the couples had multiple presenting problems (such as substance abuse, poverty, and health problems), which made the police and other service providers feel powerless to help them and required them to focus on the most immediate crisis rather than explore underlying causes. Only four of the women in the 17 couples went to transition houses or other shelters, and they did not stay long enough to use their services. The remainder did not seek the support of a transition house or called and were told there was no space available. A number of people working in transition houses told the author that they did not have the outreach resources to effectively reach some of the more remote rural communities. A lack of shelters for men in rural communities was a significant problem. None of the men in the study were referred to men's counselling programs. In many of the communities such programs did not exist at the time. Most of the existing programs did

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<sup>335</sup> "Changing Perspectives," Executive summary, p. xix.

<sup>336</sup> "Changing Perspectives," Executive summary, p. xix.

<sup>337</sup> "Changing Perspectives," Executive summary, p. xx.

not treat men who deny their violent behaviour, meaning that there was no counselling available for those men.

- e. The need for improved policies and training on identifying and responding to violence. When developing policies,

consideration must be given to the imbalance in the power dynamics of violence relationships, which usually results in women being the victims of coercive control and violence. In this respect, consideration must also be given to how and why women become violent, and why men become the victims of violence.<sup>338</sup>

Child protection agencies also failed to address the safety of women. Their focus on the welfare of children and lack of engagement with the male abusers who had left the home led them to ignore the women's continued safety as long as they appeared to be attempting to protect the children. Health care providers' tendency to focus on diagnosis with predictable methods of treatment led them to miss opportunities to properly identify the danger facing the patient or their spouse and to intervene and provide adequate treatment or services.

- f. Racism, both systemic and individual, which resulted in a lack of understanding of and sensitivity to people and also led to missed interventions. The vast majority of service providers were white, and members of the Black community interviewed by Ms. Mahon said they were not comfortable accessing predominantly white service providers, given the discrimination and racism they may experience. Black women were also protective of their families and communities and reluctant to testify against their partners. A lack of understanding of cultural differences and the impacts of racism led to service providers misunderstanding women's reactions, providing inappropriate supports, and missing opportunities for intervention.
- g. A lack of early intervention and public education programs. An early prevention strategy could address childhood abuse, self-esteem, male/female roles, conflict resolution, and relationship violence. Virtually all the people interviewed for the study also spoke of the need for public education and awareness.
- h. Problems with the accessibility of information, support, advocacy, and counselling for women and men:

There is a need to provide coordinated, comprehensive, and accessible community-based services to all women and men that are reflective of the communities in which they are located. This would include sensitivity to: rural populations; all ethnic communities; persons with disabilities; different age groups; and sexual orientation.<sup>339</sup>

The Report made recommendations focused on the key issues identified in the study. The recommendations focused on strategies for crisis intervention, long-term support, and prevention. Given the author's findings that the women who killed their partners did so in the context of recurring and escalating violence by their partners, the recommendations focused on the women as the primary victims of violence and on men as the primary perpetrators of violence. The author stated:

At any number of intervention points in this study, if the violence had been identified, and an appropriate intervention had occurred, the homicides may have been prevented. While

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<sup>338</sup> "Changing Perspectives," Executive summary, p. xvii.

<sup>339</sup> "Changing Perspectives," Executive summary, p. xxvi.

this study cannot conclude that every violent relationship will lead to homicide, it can strongly suggest that appropriate interventions in violent relationships could prevent a potential homicide. The recommendations assume therefore that appropriate interventions in all violent relationships will not only likely prevent a homicide from occurring but will enable women, children, and men to live in a domestic violence-free environment.<sup>340</sup>

The Report also included a chapter containing guidelines for the implementation of the recommendations. The author noted that in recent years, violence against women had resulted in a number of studies by government and non-governmental organizations:

Many of the studies contain recommendations for improved collaboration and co-operation between all organizations and individuals with a role to play in eliminating violence against women. Unfortunately, a major obstacle to implementation has been the failure to identify a specific process for responding to these recommendations.<sup>341</sup>

The implementation guidelines were developed during a workshop attended by the members of the study's Research Advisory Committee and the people who participated in the study's analysis consultation.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

- a. (Recommendation 1-1) The Nova Scotia government should formally declare that the province and its residents advocate and practice living in a domestic violence-free environment, where family violence in all aspects, including intimate partner violence, child abuse, and elder abuse is not acceptable and will be acted upon as criminal offences.
- b. (Recommendation 1-2) The Nova Scotia government should commit to working toward ending discriminatory practices based on sex, race, class, age, ability, or sexual orientation that are perpetuated through schools, government agencies, workplace, the family, and the media. The two areas of discrimination that have particularly surfaced in this study have been sexism and racism.
- c. (Recommendation 1-2-1) The Nova Scotia government should acknowledge that sexism fundamentally impacts on lives of residents of Nova Scotia. Sexism shapes women's and men's attitudes and images about themselves, their intimate partner, their relationships and their expectations about jobs and careers. It impacts on women's right to live in a domestic violence-free environment and their ability to make choices about work, careers, and living arrangements. It impacts on men's beliefs about their ability to take power and control in relationships. Sexism impacts on women when men become violent to maintain their control and power in relationships and when men escalate the violence when their partner wants to be more independent from them.
- d. (Recommendation 1-2-2) It is imperative that the Nova Scotia government recognize that racism has created barriers for the Black community, the Mi'kmaq community, and other ethnic communities, to education and employment opportunities and to accessing resources and services that are reflective of the culture or their experience. This has led to self-protection, fear, and a mistrust of the predominantly "White" system. These barriers should be addressed in order for women of ethnic groups to live in a domestic violence-free environment.

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<sup>340</sup> "Changing Perspectives," p. 252.

<sup>341</sup> "Changing Perspectives," p. 273

- e. (Recommendation 1-3) The Nova Scotia government should work toward eliminating the social and economic barriers for women to leave their partner or that force them to go back to their partner such as access to an adequate level of income.
- f. (Recommendation 1-4) The Nova Scotia government should recognize that the central issue for women who were experiencing violence by their intimate partner is safety. Women must feel emotionally and physically safe in order to disclose the violence. They need to know they will be protected and believed. Women must be able to make their choices through consistent information, consistent support, and consistent responses when they request help. Women who have been in violent relationships require advocacy, self-esteem building, counselling, adequate childcare, an adequate income, accessible and affordable housing, and help with legal issues.
- g. (Recommendation 1-5) The Nova Scotia government should recognize that the central issue for men who are violent is accountability. Men must be made accountable for their violent behaviour through consistent enforcement of criminal laws and through constructive confrontation to address the denial of the violence. Men need information, education, and counselling to address changes in behaviour and attitudes. The government must recognize [that] the effect of not consistently making men accountable for their behaviour is to reinforce women's silence about the violence and to reinforce that violence is a private matter.
- h. (Recommendation 1-6) The Nova Scotia government should recognize that there are stages to intervention in intimate partner violence. Those stages are prevention, crisis, and long-term support. Strategies must address all three stages.
- i. (Recommendation 1-7) The Nova Scotia government should continue with its commitment to a coordinated strategy to address the issue of intimate partner/ex-partner violence through the Family Violence Prevention Initiative. This study has shown that no one single area can be designated as responsible for dealing with this issue. It is important that there should be awareness among the general public, that there should be coordinated community-based responses, and that there should be commitment to a coordinated response by the justice, health care, social services, education systems, the workplace and the church.
- j. (Recommendation 1-8) The Nova Scotia government should recognize the importance of and ensure that there should be accountability for directives, procedures, and protocols related to identifying and responding to intimate partner/ex-partner violence.
- k. (Recommendation 2-1) All government agencies and community supports should develop identification and response protocols.
- l. (Recommendation 2-2) All policies and procedures must be considered in the development of protocols. Policies and procedures that would re-victimize women for disclosing the violence should be eliminated, (e.g., potential of losing income, losing custody of children, losing housing).
- m. (Recommendation 2-3) All protocol development should be specific and appropriate to the mandate of the agency. Protocols should include the following elements for both women and men:
  - a. Procedures to identify violence
  - b. Procedures for provision of information and support to the victim of violence
  - c. Procedures for referral to appropriate community agencies
  - d. Procedures for provision of information for men to appropriate men's counselling programs
  - e. Procedures and mechanisms for documentation of the violence

- f. Procedures and mechanisms for communication to other components of the particular system or to other systems
  - g. Procedures and mechanisms for follow-up
  - h. Procedures to ensure consistency of response.
- n. (Recommendation 2-4) All training should include the realities of the dynamics of violent intimate partner relationships, the impact on individuals, the community and their particular government agency or community organization, and the appropriate response according to the agency mandate and protocol.
  - o. (Recommendation 2-5) All workers/service providers should receive ongoing training in the dynamics of violent relationships.
  - p. (Recommendation 2-6) This training should be provided for both new appointees/staff appointments and as in-service courses at regular intervals.
  - q. (Recommendation 2-7) This training should promote an understanding of the various patterns of violence, the contributing factors associated with escalating violence, and the power imbalance in the dynamics of violent relationships. It is important that everyone gain an understanding of the seriousness of economic and psychological violence. Threats, stalking, forced isolation, intimidation, threats of suicide, “suicide pacts,” and use of the children are all methods of psychological terrorism and must be treated seriously. Training should include the impact of violence on women—why women do not want to disclose the violence and why women reconcile with a violent partner. Training should include that men tend to deny the violence and blame the problems in the relationship on the women. Training should also include why some women become violent and why some men become victims of violence.
  - r. (Recommendation 2-8) This training also should address personal barriers to identifying the violence, such as attitudes, beliefs, and values about male/female roles in relationships, personal experiences with violence, and raise sensitivity and awareness on attitudes and behaviours that may be racist, sexist or classist.
  - s. (Recommendation 2-9) Workers should have training in nonviolent crisis intervention and workers should address their fears and anxieties in dealing with some clients.
  - t. (Recommendation 2-10) All protocols and training should recognize that the central emphasis should be on the safety of the woman who is abused, and all procedures in contacting and communicating with the woman should concentrate on continuing to support her to make choices, to believe her, and to be non-judgmental regarding her decisions to stay, not to testify, or to reconcile with her partner.
  - u. (Recommendation 2-11) Black communities, Mi’kmaq communities, and other ethnic communities should have services that are reflective of their culture and that understand their experience.
  - v. (Recommendation 2-12) All government agencies and community supports should create environments that are sensitive to and accessible to the Black communities, Mi’kmaq communities, and other ethnic communities.
  - w. (Recommendation 2-13) All government agencies and community supports should consider the particular barriers to people living in isolated rural communities, to persons with disabilities, to various age groups, to people with limited incomes, and to sexual orientation. (Although sexual orientation was not identified as a particular barrier in this study, it could be a barrier to disclosure of violence in an intimate partner relationship).
  - x. (Recommendation 2-14) All workers/service providers should have ongoing sensitivity training.

- y. (Recommendation 2-15) All government agencies and community supports should include education on addictions for all service providers and supervisors, on how to intervene appropriately for women and men with addictions.
- z. (Recommendation 2-16) All government agencies and community supports should develop partnerships within local communities to offer support to themselves, to share expertise, to add expertise to their service delivery, and to enhance a coordinated response.
- aa. (Recommendation 2-17) All government agencies and community supports should develop mechanisms to assist police and workers with cases that involve multiple issues, to ensure that the response does not deteriorate.
- bb. (Recommendation 2-18) All team case management approaches should include comprehensive approaches to the situation and that has client support as its central focus. Violence and the woman's safety must always be considered as a potential area of consideration.
- cc. (Recommendation 2-19) An assessment instrument should be developed that clearly identifies the presence or absence of contributing factors to escalating violence.
- dd. (Recommendation 2-20) Such an assessment instrument should be administered either through men's counselling programs or through the criminal justice system, with appropriate training.
- ee. (Recommendation 2-21) Assessments should be completed prior to sentencing or prior to application for a judicial interim release, or show cause hearing to determine if the suspect/offender can be released into the community.
- ff. (Recommendation 3-1) All police officers, Crown Prosecutors, judges, probation officers, corrections officers and Victim's Services staff should be given appropriate tools, protocols, training, documentation, communication, and resources to effectively intervene in intimate partner/ex-partner violence.
- gg. (Recommendation 3-2) All police officers, Crown Prosecutors, judges, probation officers, corrections officers, judges, and Victim's Services staff should receive comprehensive and ongoing training in the dynamics of violent relationships, as described in Training and Protocol Development.
- hh. (Recommendation 3-3) In addition to the basic elements of protocols identified under Training and Protocol Development, all criminal justice protocols should include that the woman be given information about conditions of orders and her options for reporting breaches, about changes in incarceration dates, including temporary absences or early releases, about any violations of orders and/or including not meeting conditions of orders due to denial of the violent behaviour.
- ii. (Recommendation 3-4) All components of the criminal justice system should reinforce to offenders of intimate partner/ex-partner violence at each stage of the proceedings that it is the responsibility of the criminal justice system to prosecute all offences involving partner/ex-partner violence. This will include, at the time of arrest, application for judicial interim release, preliminary hearing, trials, sentencing, violations of orders, and no contact conditions.
- jj. (Recommendation 3-5) All components of the criminal justice system should reinforce to offenders of intimate partner/ex-partner violence that no contact means no contact, including letters, phone calls, and gifts.
- kk. (Recommendation 3-6) All policing agencies should follow the charging directive.

- ll. (Recommendation 3-7) Upon review of the criminal harassment law,<sup>342</sup> a new charging directive should be issued to all policing agencies and Crown Prosecutors. This new directive should include the criminal harassment law.
- mm. (Recommendation 3-8) All police should receive training on the criminal harassment law.
- nn. (Recommendation 3-9) A police response protocol should be developed and adhered to by all police agencies in Nova Scotia in their response to cases of intimate partner violence. The police protocol must include procedures for documentation of the incident and the history of violence in the relationship. Given the findings of the study, the protocol must include the following: that under no circumstances will the demeanour of the woman or man, or past knowledge of her/his behaviour be a determinative factor in consideration of laying of a charge; that under no circumstances will the presence or absence of alcohol on the part of either parties be the determinative factor in the consideration of the laying of a charge; that under no circumstances will a woman be asked either directly or indirectly if she wants charges laid by the police, if she wants to lay charges or if she is willing to follow through with charges or testify in court; that both parties will be advised that it is the responsibility of the police to lay the charge(s)....
- oo. (Recommendation 3-10) All police should receive training to improve their understanding of issues related to women and addictions.
- pp. (Recommendation 3-11) All telephone calls to dispatch and to individual police officers, all contacts, all interventions, and all charges related to the woman or the man should be documented and linked so that patterns of behaviour and violence can be detected and tracked. This would include all the kinds of contacts identified in this study and calls from the woman and others including transition house staff, clergy, neighbours, family members.
- qq. (Recommendation 3-12) Police information systems should be linked so that peace bonds, charges, dispositions, and violations of court orders can be shared between neighbouring policing agencies.
- rr. (Recommendation 3-13) When charges are laid and the basis for the behaviour or the intent is related to intimate partner/ex-partner violence, a mechanism should be developed to link the charge to the violent behaviour and the charge should automatically become indictable. This may involve changes to the Criminal Code of Canada, e.g., damage to property with intent, similar to Break and Enter with intent. The mechanism *must* indicate to the Crown prosecutor and to the judge that the offence is a pattern of intimate partner/ex-partner violent behaviour.
- ss. (Recommendation 3-14) Mechanisms should be developed to document the patterns of violence, such as stalking, forcible confinement, or a homicide-suicide plan. Such documentation should be presented to the Crown Prosecutor as a serious situation. The Crown Prosecutor should request a show cause hearing, based on this documentation, to detain in custody to the court hearing.
- tt. (Recommendation 3-15) Better mechanisms should be developed to remove the man from the home. In some cases, the woman was arrested and locked up for public intoxication because she ran outside after the police or was pushed outside by her partner.
- uu. (Recommendation 3-16) In all cases of intimate partner/ex-partner violence and when an offence is alleged to have been committed under the Criminal Code of Canada and/or any other applicable legislation, the police should exercise their powers of arrest, whether the

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<sup>342</sup> At the time of the study, laws pertaining to stalking were under review.

alleged offence be summary conviction, hybrid, or indictable, in all but the most exceptional cases.

Pursuant to Section 495(1) of the Criminal Code, a peace officer may arrest without a warrant in certain cases, such as when the peace officer has reasonable and probable grounds to believe that a person has committed or is about to commit an indictable offence, or if the peace officer finds a person committing a criminal offence.

Section 495(2) of the Criminal Code states that peace officer shall not arrest a person without a warrant for, *inter alia*, offences punishable on summary conviction, or offences for which the person may be prosecuted either by indictment or by way of summary conviction (hybrid offences), in any case where:

(d) he believes on reasonable grounds that the public interest, having regard to all the circumstances including the need to (i) establish the identity of the person, (ii) secure or preserve evidence or of relating to the offence, or (iii) prevent the continuation of the offence or the commission of another offence, may be satisfied without so arresting the person.

In situations of intimate partner/ex-partner violence where repetition of offences do occur, the police officer could exercise powers of arrest for summary offences such as assault, breach of recognizance, and breach of probation under (d) (iii).

Under Section 542(2), a peace officer has the power to arrest a person without a warrant when he or she believes on reasonable grounds that the person has disobeyed or is about to disobey any conditions of judicial interim release, or has committed an indictable offence while on judicial interim release.

- vv. (Recommendation 3-17) Police should fully investigate and lay violations on court orders, including probation, peace bonds, recognizances and undertakings and not “second guess” whether the court will treat the violation seriously.
- ww. (Recommendation 3-18) Police should remove firearms, ammunition, and explosive substances from the premises of any offender who has a prohibition order through the court.
- xx. (Recommendation 3-19) The police should give priority to responding to the violence committed against a woman and that any unrelated violations or warrants for her arrest that come to their attention as the result of their intervention be dealt with at a later time.
- yy. (Recommendation 3-20) Upon notification, the police should immediately arrest and detain for a show cause hearing any offender who is on a court order with a no contact clause who has breached the condition of the no contact condition.
- zz. (Recommendation 3-21) No contact condition on a court order should be interpreted as absolutely no contact, which would include no phone calls and no letters.
- aaa. (Recommendation 3-22) Upon notification, the police immediately arrest and detain any offender who violates a condition of an order who is on bail awaiting appeal for a violent offence.
- bbb. (Recommendation 3-23) All police agencies should record particulars of all orders and conditions of orders, in particular no contact conditions, on CPIC (Canadian Police Information Centre) and on their information systems within 24 hours of receiving confirmation of the granting of any such order.
- ccc. (Recommendation 3-24) The police should notify the probation officer within 24 hours if an offender on probation has been charged with any offence or a violation of an order.

- ddd. (Recommendation 3-25) Every police agency should have a specialist in domestic violence who can be consulted regarding issues related to specific cases, who can assist in the identification of patterns and appropriate police response. Files would be referred for review and follow-up.
- eee. (Recommendation 4-1) All income assistance workers, maintenance support caseworkers, and child protection workers should be given appropriate tools, protocols, training, documentation, communication, and resources to effectively and appropriately intervene in intimate partner/ex-partner violence.
- fff. (Recommendation 4-2) All income assistance workers, maintenance support caseworkers, and child protection workers should receive comprehensive and ongoing training in the dynamics of violent relationships. It is recommended this training will be provided for both new appointees/staff appointments and as in-service courses for at regular intervals.
- ggg. (Recommendation 4-14) Section 22.(2)(i) of the Children and Family Services Act should undergo a serious review.<sup>343</sup> The section as it is currently written should be eliminated altogether. The review should consider the delineation of the direct violence the child experiences by a parent or guardian, from the violence the child witnesses by one parent or guardian toward the other parent or guardian. With respect to the child(ren) witnessing violence by one parent or guardian toward another, the review should consider the following:
- a. (Recommendation 4-14-1) The realities of the dynamics of violent intimate partner relationships;
  - b. (Recommendation 4-14-2) The perpetrator of the violence should be required to take responsibility for their violent behaviour;
  - c. (Recommendation 4-14-3) The parent or guardian who is in receipt of the violence should not be required to take responsibility for the perpetrator's violent behaviour;
  - d. (Recommendation 4-14-4) The violence by an abusive parent against another parent can impact on the parent and the child, whether the perpetrator is living in the household or has separated or divorced from the custodial parent (e.g., stalking the custodial parent);
  - e. (Recommendation 4-14-5) The actions necessary to remove the perpetrator from the household or from contact with the other parent and children, when the perpetrator who may or may not be living in the household, fails to obtain services or treatment to remedy or alleviate the violence; and
  - f. (Recommendation 4-14-6) Protocols and procedures to protect the safety of both the victim and the children.
- hhh. (Recommendation 4-15) Child Protection agencies should consider policies, procedures, and practices that encompass an understanding of the potential impact that the parent's behaviour may be having on the children and the custodial parent.
- iii. (Recommendation 4-16) Protocol development for child protection agencies must take into consideration the particular problems associated with the fear that disclosure of the violence may mean risking losing custody of children.
- jjj. (Recommendation 5-1) All service providers in health care professions receive comprehensive and ongoing training in the dynamics of violent relationships as described in

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<sup>343</sup> At the time, this provision of the Act read: "(2) A child is in need of protective services where ... (i) "the child has suffered physical or emotional harm caused by being exposed to repeated domestic violence by or towards a parent or guardian of the child, and the child's parent or guardian fails or refuses to obtain services or treatment to remedy or alleviate the violence." The current version is very similar.

Training and Protocol Development. This training will be provided for new staff appointments and as in-service courses offered at regular intervals.

- kkk. (Recommendation 5-2) The health care professionals identified through this study and who would be appropriate for this training are: all nurses, doctors (particularly those in family practice), psychiatrists, dieticians, occupational therapists, physiotherapists, psychologists, social workers, and counsellors in Drug Dependency programs.
- lll. (Recommendation 5-3) It should be recognized that diagnostic categories do not facilitate a full understanding of all the issues surrounding violence in intimate partner relationships.
- mmm. (Recommendation 5-4) Protocols should be developed and adhered to for all hospitals, for all community health clinics, for all mental health clinics, and for all doctors in family practice. Protocols should include procedures for asking women directly about the abuse, listening and believing the woman, providing information and referral to community resources.
- nnn. (Recommendation 5-5) A protocol should be developed to identify and respond to abusive men for family doctors, mental health service providers, and Drug Dependency counsellors. Protocols should include training to listen to an abuser, support changes in his behaviour, and to encourage him to seek help in a counselling program for batterers.
- ooo. (Recommendation 5-6) Marriage counselling should not be considered an option for couples in a violent relationship until the man receives individual treatment for his violent behaviour. Men should be referred to programs that help them to take responsibility for their violent behaviour.
- ppp. (Recommendation 5-7) Mental health assessments should be reviewed to facilitate the identification of intimate partner violence and to identify contributing factors to a high-risk situation. In conducting mental health assessments, the questions of cause and effect should be seriously considered, e.g., whether it is the depression that helps cause the violence, or does the violence contribute to the depression in the abuser. The findings of this study support effect rather than cause—that the men's violence contributed to a deterioration in their emotional health.
- qqq. (Recommendation 5-8) A mechanism must be developed to ensure that women are protected from men who are diagnosed with a mental illness and found not criminally responsible for their violent behaviour in the justice system. Regardless of the diagnoses, the man is still at high risk of killing the woman.
- rrr. (Recommendation 5-9) A protocol should be developed between Drug Dependency and probation whereby the court is informed if, after an assessment, the conditions of the probation order have not been met. This would include where the offender did not take treatment for the substance abuse due to denial, lack of motivation, or lack of co-operation. This would also include the cases of repeated referrals through conditions on probation orders, where the offender is not addressing the substance abuse problem for the same reasons. The court would then have information upon which to determine appropriate sentencing alternatives or appropriate conditions on probation orders.
- sss. (Recommendation 5-10) A strong emphasis and appropriate resources should be allocated to Drug Dependency for education and other programs related to the prevention of alcohol and drug abuse. An aggressive preventative strategy is recommended because Drug Dependency was unable to treat many of the addicted women and men due to lack of motivation and denial, and because many of the addicted men began drinking heavily as teenagers.

- ttt. (Recommendation 5-11) Programs specifically for addicted women should be established throughout the province to include advocacy, drug treatment and education, childcare, self-esteem and self-confidence development, information on the family nature of addiction, therapy for sexual abuse and childhood abuse, and job skills and upgrading.
- uuu. (Recommendation 9-1) Community Advocacy Response Teams should be created to provide advocacy, support, and assistance to families, including women, men, and the children.
- vvv. (Recommendation 9-2) Transition house outreach services, men's counselling programs, police, and health care professionals should be an integral component of the Community Advocacy Response Teams.
- www. (Recommendation 9-3) Transition house services should be adequately funded to provide comprehensive outreach programs in rural communities in Nova Scotia; a toll-free 24-hour advocacy and crisis line; and programs for teen women (if such programs are not currently offered in alternate ways in their communities). Appropriate and accessible counselling for women survivors should be instituted, either through the outreach services of transition houses or by specially trained counsellors within mental health clinics
- xxx. (Recommendation 9-4) Transition houses should consider the promotion of a new public image in light of broad range of programs and services they currently offer, that are not housing related, in order to effectively reach those women who need information, education, advocacy and support and do not currently access their services because they do not need housing, are not physically abused, or are not economically disadvantaged.
- yyy. (Recommendation 9-5) All transition house services, including outreach services and programs, should be reflective of the communities in which they are located.
- zzz. (Recommendation 9-6) Black communities, Mi'kmaq communities, and other ethnic communities should have services for women that are reflective of their culture and that understand their experience. These communities should be involved in the design of programs and services, training of staff, and have control over the delivery of the services in their community.
- aaaa. (Recommendation 9-7) Men's counselling programs should be adequately funded. Men's counselling programs must recognize that denial is an integral part of violent behaviour. Programs must address motivation, address denial of the violence, and ensure that men take responsibility for their behaviour and for changing their behaviour.
- bbbb. (Recommendation 9-8) Men's programs should include educational programs for teen men and counselling programs for abusive teen men.
- cccc. (Recommendation 9-9) A set of provincially recognized standards should be developed to provide guidance and consistency to men's counselling programs.
- dddd. (Recommendation 9-10) Men should be mandated to counselling through the justice system; there must be accountability for attendance at programs to the supervising probation officer.
- eeee. (Recommendation 9-11) Black communities, Mi'kmaq communities, and other ethnic communities should have services for men that are reflective of their culture and understand their experience. These communities should be involved in the design of programs and services, training of staff, and have control over the delivery of the services in their community.
- ffff. (Recommendation 9-12) If men refuse to take counselling or remain in denial of their violence there must be accountability through the probation officer, to the Crown and court. Protocols

should be established to inform the woman that the man remains in denial of his violent behaviour.

- gggg. (Recommendation 9-13) Public education should be an ongoing commitment of the provincial government and coordinated through the Family Violence Prevention Initiative.
- hhhh. (Recommendation 9-14) Education on the dynamics of violent relationships, its impact on individuals, the family, the community and their profession, and appropriate responses for their profession, should be a component of the college and university curriculum for police, lawyers, doctors, nurses, nurse practitioners, physiotherapists, occupational therapists, social workers, psychologists, teachers, and the clergy.
- iiii. (Recommendation 9-15) Educational institutions should integrate an educational component into the school curriculum for elementary, junior high and high schools as a long-term prevention measure...
- jjjj. (Recommendation 9-16) All teachers and administrators should receive comprehensive and ongoing training in the dynamics of violent relationships and child abuse. It is recommended this training should be provided for both new appointees/staff appointments and as in-service courses for at regular intervals.
- kkkk. (Recommendation 9-17) Specific protocols should be developed and adhered to that will assist teachers in the recognition of and the provision of support and referral for children who are in abusive situations and for teens who are in abusive situations or who are abusive. Safety will be of utmost importance both in the disclosure and follow-up.
- llll. (Implementation Guideline 1) The Minister of Justice should refer the report "Changing Perspectives" to the Deputy Ministers' Committee on Social Policy.
- mmmm. (Implementation Guideline 2) Each department represented on the Deputy Ministers' Committee should review and analyze the recommendations contained in the report and prepare a response.
- nnnn. (Implementation Guideline 3) Relevant community organizations should also develop a response based on a review and analysis of the recommendations.
- oooo. (Implementation Guideline 4) The responses should be submitted to the Family Violence Prevention Initiative (FVPI) for review by a Family Violence Action Committee (a subcommittee of the FVPI composed of representatives from government and community).
- pppp. (Implementation Guideline 5) It is recommended that a senior staff member of one of the departments represented on the FVPI be seconded to chair the Action Committee on a full-time basis for a one-year period, supported by an administrative assistant. This individual would be responsible for liaising with government departments and community organizations to develop an action plan for responding to the report recommendations. Outcome measure would also be devised to facilitate the analysis of progress toward goals.
- qqqq. (Implementation Guideline 6) The Family Violence Action Committee will present regular reports to the Deputy Ministers' Committee regarding results.
- rrrr. (Implementation Guideline 7) Key outcome measures (benchmarks) will be reported to the public on a regular basis.

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### 6.1.2. Nova Scotia Family Violence Tracking Project (1995)<sup>344</sup>

The Nova Scotia Family Violence Tracking Project was a joint initiative of the Solicitor General of Canada and the Nova Scotia Department of Justice. The goal was to obtain detailed information on trends and patterns in family violence and the justice system's response to these offences. The Executive Summary focused on spousal and child abuse and included all offences committed in the context of an abusive relationship. The authors defined abuse to include physical and sexual abuse, psychological and emotional abuse, economic abuse in the form of withholding resources necessary to meet basic needs, and neglect. Psychological and emotional abuse included persistent verbal aggression, isolation, intimidation, humiliation, threats to harm the victim or others, threats to pets or property, and other behaviour intended to control, humiliate, instill fear in the victim, or diminish the victim's sense of self-worth. The authors reviewed the historical police response to spousal abuse in Canada and elsewhere and noted that the first significant policy changes in the United States resulted from class action lawsuits brought by victims against police for failing to protect them from physical abuse. In Canada, policy changes resulted from key research studies and special committees examining wife abuse.

The Project examined all family violence cases reported to 29 police sites in Nova Scotia over six months. The sites included thirteen municipal forces and sixteen RCMP detachments. A total of 1,157 cases of family violence were reported in this period, the vast majority of which were spousal abuse. 40% (458) of these reports led to charges, and of those, 58% of the offenders (228) were convicted. 30% of those convicted (69) were incarcerated, and 81% received probation. Close to half of those incarcerated were given sentences of 30 days or less.

The Report then examined police reports of spousal violence cases specifically. Two thirds involved reports of physical assault, and the majority also involved psychological abuse. Threats were involved in 40% of the reports. Where charges were not laid, the primary reason was that the victim was reluctant (40% of cases). Charges were also found to be "unfounded" in 20% of cases. Perpetrators were charged with threats in only 13% of the cases. Almost no evidence was gathered other than victim testimony.

The Report identified significant problems with the police response, including:

1. Failure to dispatch, particularly where the victim reported threats. Victims were typically advised to come to the station to lay a complaint. This was identified as discouraging victims, particularly in rural areas, from coming forward.
2. Ineffective response to threats. The vast majority of threat reports were not considered urgent.
3. Failure to charge. Despite the mandatory charging policy in place, police were not following that policy and were continuing to place the decision to charge on the victim. Police also failed to lay charges for a range of offences other than assault, and the majority of offenders were not detained or given conditions preventing contact or weapons.
4. Although weapons were involved in 161 of the cases, only 34 were seized.
5. Failure to obtain a statement from the victim; and
6. Failure to search for prior complaints, charges, or convictions, and poor documentation of family violence complaints.

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<sup>344</sup> "The Response of the Justice System to Family Violence in Nova Scotia: Executive Summary," Nova Scotia Family Violence Tracking Project (1995).

The Report also identified problems with the response of Crown Attorneys, who often drop or reduce the few charges that are laid, particularly threats. Plea bargaining reinforces the perception that most wife battering is minor in nature. There was little support for victims prior to trial, which led many women to recant or fail to appear at trial. Sentences were lenient and sent a message to victims that the outcome was not worth the effort of participating in the proceedings.

Only one third of offenders placed on probation were required to attend treatment. The Report stated that “Intervention or treatment for less than six months is unlikely to change abusive behaviour.”<sup>345</sup> Almost 40% of the offenders breached their conditions of probation, most often failing to comply with treatment requirements and contacting their partners. Only half of these men were charged with breaching. The Report noted that separation is the most dangerous point for women, “yet this is the point at which the response of the justice system is weakest.”<sup>346</sup>

The authors also interviewed 76 women who had experienced spousal abuse, identified through their admission to transition houses in Nova Scotia. Some of the women reported that their partners “abused them in sadistic, cruel, and torturous ways and delighted in the power of watching the suffering of others, both people and animals.”<sup>347</sup> Virtually every woman had been threatened. Only 35% of the abusers had ever been charged. More than half had been threatened or armed with a weapon, and 38% with a firearm. The women reported devastating long-term effects of the abuse, including nervous disorders, acute anxiety, and panic attacks. Some went into hiding. The women who did not call police said they felt it was futile to do so and/or it would make the abuser even angrier. Two thirds of those who did call police were not satisfied with the police response, in most cases because the police failed to remove the abuser. They also reported that the police did not have a supportive attitude to them. Charges were only laid in 36% of calls. Most of the women believed the criminal justice system is ineffective and does not treat violence against women seriously.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. It is recommended that the Nova Scotia Department of Justice and Solicitor General Canada request the federal Department of Justice to consider amending section 268 of the Criminal Code to include death threats and threats of bodily harm as elements constituting aggravated assault.
2. It is recommended that the Nova Scotia Department of Justice reinforce the directive of charging with police and that it be accompanied by training and internal and external accountability procedures that hold both individual police officers and police agencies responsible for compliance. Police should lay charges where evidence warrants, including charges for threats and other offences, not simply assault, to the full strength of the law. Police should be instructed not to advise victims to lay their own charges or ask them if they want charges laid. Police should also be instructed to advise victims of services available.
3. It is recommended that police agencies conduct regular internal audits of their domestic dispute and assaults, including monitoring dispatch rates and ensuring appropriate charges are laid. Police supervisors should follow up with the appropriate officer for every domestic violence case that does not result in a charge.

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<sup>345</sup> “The Response of the Justice System: Executive Summary,” p. 22. The source of this statement was not identified in the Executive Summary.

<sup>346</sup> “The Response of the Justice System: Executive Summary,” p. 20.

<sup>347</sup> “The Response of the Justice System: Executive Summary,” p. 30.

4. It is recommended that police exercise greater diligence to ascertain the presence of weapons at the complaint-taking/dispatch stage; investigate and seize any weapons used in the commission of an offence, particularly firearms; and take steps to revoke a Firearms Acquisition Certificate belonging to anyone who has been convicted of a violent offence or has threatened to use a firearm to harm another.
5. It is recommended that police be encouraged to take victim statements at the scene or as soon as practicable thereafter and to supplement such statements with other evidence.
6. It is recommended that police make more expeditious use of information through the following means:
  - a. Improved documentation for family violence complaints. Every complaint should receive full documentation at the point of call/complaint-taking, including a victim–offender relationship identifier for the file. Charge rates should be routinely entered on computer.
  - b. Dispatcher access to all available information (i.e., past histories, court orders, peace bonds, parole notices, temporary absence notices, and other relevant information), computerized or not;
  - c. Information searches on domestic disputes prior to arrival at the scene;
  - d. Forwarding all relevant information and recommendations for release conditions to the Crown.
7. It is recommended that offenders who have shown themselves incapable of complying with conditions of probation be given a period of incarceration. If treatment is a condition of probation, supervision is recommended to ensure attendance.
8. It is recommended that treatment of six months or more be required for offenders, where recommended, and that some means of evaluation be built into the treatment programs.
9. It is recommended that appropriate programs should be available and accessible to family violence offenders. Every effort should be made to accommodate these offenders in a facility with a treatment program.
10. It is recommended that the provincial and federal governments increase efforts to prevent family violence, such as public and professional education, early intervention programs, education and support to high-risk families.
11. It is recommended that the Government of Nova Scotia monitor the response of the justice system, assessing the impact and effectiveness of various programs, protocols, procedures, and directives in handling family violence cases.
12. The Family Violence Prevention Initiative maintain its commitment to multidisciplinary training, recognizing that a truly effective response to family violence will require the collaborative efforts of all those with a role to play in addressing this serious social problem.
13. It is recommended that the Family Violence Tracking System be implemented province-wide. Cases should continue to be tracked on an individual basis, examining court and corrections data in addition to police data. The Department of Justice should use the Family Violence Tracking System to monitor the activities of the criminal justice system, stressing the importance of accurate data collection and documentation. It is recommended that a person be vested with this responsibility on a full-time basis. In addition to analyzing the findings from the Family Violence Tracking System, responsibilities ought to include the development of policies, programs, and procedures to improve the response of the justice system to family violence.

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### 6.1.3. “From Rhetoric to Reality: Ending Domestic Violence in Nova Scotia” (Law Reform Commission of Nova Scotia, 1995)<sup>348</sup>

The Law Reform Commission of Nova Scotia submitted this Report to the Government of Nova Scotia in February 1995. The Report reviewed the pervasiveness of intimate partner violence in Nova Scotia and Canada, the social and legal context, and the history of domestic violence policies and approaches in Nova Scotia. It documented numerous instances of police belittling women who reported assaults and refusing to lay charges or remove the abuser, in spite of mandatory charging policies. The Commission concluded that “[s]ince the law in Canada already clearly prohibits harassments, threats and all forms of physical violence, it appears that the existing law is not obeyed or respected.”<sup>349</sup> Although some changes could be made to the laws and court structure, the heart of the problem was the way existing laws were being enforced:

Ultimately, and perhaps surprisingly for a legal research agency, the Commissioners concluded that the social and legal problems involved in domestic violence are not unknown or insoluble. The issue does not require a great deal more study or more laws, but rather response to existing information and enforcement of existing laws...

[T]he lack of coordination of resources devoted to dealing with the issue suggests that domestic violence is still not understood to be the large scale problem that it is.<sup>350</sup>

The Report called on the government to ensure that its policy against domestic violence is implemented at all levels: “All forces of society should be combined in actively seeking to prevent and punish this violent crime.”<sup>351</sup>

#### Recommendations Relevant to Mandate of the Mass Casualty Commission

1. (Recommendation 1) It is critical that the government of Nova Scotia make the eradication of domestic violence a priority to which it will target action and resources.
2. (Recommendation 2) The legal response to domestic violence should include improvements both in the criminal and the civil law systems and their delivery.
3. (Recommendation 3) The life-threatening nature of domestic violence, its immense social cost, and the barrier to equality for women must be explicitly recognized in the legal and resources response.
4. (Recommendation 4) The law must ensure that, in addition to protection of women, the fact that domestic violence is socially unacceptable is communicated with clarity and certainty.
5. (Recommendation 5) Develop system-wide interdepartmental Protocols for handling domestic violence cases.
6. (Recommendation 6) Adopt as the central principle of the Protocols the protection and security of the woman and any other endangered people as the priority for all decisions.
7. (Recommendation 7) Commit sufficient human, education, and technical resources, including modern communication systems, to allow the Protocols to be effectively delivered.

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<sup>348</sup> “From Rhetoric to Reality: Ending Domestic Violence in Nova Scotia—Final Report,” Law Reform Commission of Nova Scotia (February 1995), <https://lawreform.ns.ca/wp-content/uploads/2020/04/domestic-violence-final-report.pdf>.

<sup>349</sup> “From Rhetoric to Reality,” p. i.

<sup>350</sup> “From Rhetoric to Reality,” p. ii.

<sup>351</sup> “From Rhetoric to Reality,” p. 8.

8. (Recommendation 8) Ensure that the existing system for monitoring cases of domestic violence is enhanced and that there is personal accountability for individuals involved in implementing the Protocols.
9. (Recommendation 9) Require that an independent agency such as the Advisory Council on the Status of Women prepare and publish an annual evaluation of the government's progress in the eradication of domestic violence.
10. (Recommendation 14) There should be province-wide specially trained interdisciplinary teams of police and government and non-government support workers to respond to domestic violence cases.
11. (Recommendation 17) There must be safe and affordable housing as transitional and long-term alternatives for women escaping domestic violence.
12. (Recommendation 18) The Matrimonial Property Act should be changed in two ways: first, domestic violence should be considered when granting an order for exclusive possession of the matrimonial home; and second, orders for exclusive possession of a shared residence should be available to all common law couples, including same-sex couples. The Act should also include leasehold interests and provide authority to make orders regarding those interests.
13. (Recommendation 23) There should not be mandatory reporting of domestic violence cases until the legal system is sufficiently developed to be able to guarantee the safety of women whose life may be endangered by unexpected police action or responses. Even in that case there should not be a requirement that support workers report domestic violence unless the woman agrees.
14. (Recommendation 24) The Minister of Justice recommend that the Unemployment Insurance Act be amended to allow a woman to leave her employment and obtain benefits if she has been subjected to domestic violence and has left her job to escape harassment from her spouse.
15. (Recommendation 28) Police officers should be directed to exercise their powers of arrest and detention in cases of domestic violence to remove and detain the abuser until released with conditions or until trial. This can be achieved provincially through system-wide Protocols. In addition, the Criminal Code provision governing arrest and detention and judicial interim release should be altered to ensure that where the domestic violence has occurred, the police, prosecution, and justices and judges are directed to arrest and detain the abuser in custody unless he obtains an interim judicial release. Justices giving release orders must be required to consider conditions prohibiting contact with the woman and possession of firearms and other conditions appropriate to the particular case, including mandatory reporting. Breaches of these conditions must result in detention until trial.
16. (Recommendation 29) The criminal offence of torture should be reviewed to make it available for use in domestic violence cases, or alternatively, a new crime of domestic violence should be created with similarly severe sanctions.

### **Implementation of the Recommendations**

The Law Reform Commission report was released the same year as “Changing Perspectives: A Case Study of Intimate Partner Homicide in Nova Scotia” (summarized above in section 6.1.1.) and a report tracking the criminal justice system's response to reports of domestic violence in Nova Scotia (summarized above in section 6.1.2). Nova Scotia responded to these reports by

launching a Framework for Action Against Family Violence in 1995.<sup>352</sup> The Framework had six key components:

1. A pro-arrest, pro-charge, pro-prosecution approach;
2. Comprehensive training of all justice workers on the dynamics of family violence and the roles of justice workers and community agencies in responding to incidents of domestic violence;
3. Enhanced victim support services;
4. Interagency coordination to improve collaboration and cooperation among agencies and individuals who play a role in addressing family violence;
5. The establishment of structured audit mechanisms and regular public reporting by each justice agency to ensure accountability and adherence to protocols and directives; and
6. Advocacy to encourage community support for strong measures by justice agencies.

Nova Scotia implemented a number of policies and procedures pursuant to the Framework, including the following:

- Creation of a Case Management Investigation Procedural Policy for police, which, among other requirements, required police to respond to and fully investigate all family violence cases, gathering as much evidence as possible at the scene to reduce reliance on victim testimony, and requiring police to lay charges and arrest and remove the alleged perpetrator from the home irrespective of the victim's wishes;
- Auditing mechanisms created by police, victims' services, and other agencies;
- Tracking of domestic violence reports to police through the court system;
- Creation of the Family Violence Prevention Initiative, a government–community committee reporting to the Deputy Ministers' Committee on Social Policy, which engaged in public education efforts, collected the results of the audits and case tracking systems put in place under the Framework, and coordinated policy development and the interagency collaboration contemplated by the Framework; and
- Funding for community-based support services.

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**6.1.4. Truro Police Service Program Review (Police and Public Safety Services Division of the NS Department of Justice, 2000); Department of Community Services Review of the Maxwell/George Case (2000); Program Review into the Deaths of Lori Lee Maxwell and Bruce Allen George (Department of Justice, 2000)**

Bruce George and Lori Maxwell started living together in May of 1998 in Canso, Nova Scotia. They moved to Truro later that year. Each had children from previous relationships, some of whom lived with them at various times. Mr. George and Ms. Maxwell had significant involvement with the RCMP in Canso, with the Truro Police Service, and with local children's aid societies. On February 28, 2000, while on probation for assaulting Ms. Maxwell, Mr. George killed her and then killed himself.

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<sup>352</sup> Department of Justice, Nova Scotia, "Framework for Action Against Family Violence" (1995). Available within the Commission's documents as COMM0001035.

The province of Nova Scotia directed reviews of the interactions of the various services with the family, including the Truro Police Service, a men’s intervention program, victims services, and child protection agencies. There was no review of the Canso RCMP involvement, which was brief. A further report by the Department of Justice summarized the results of these individual reports, as well as the involvement of Correctional Services, and examined whether the various organizations that had interacted with Ms. Maxwell and Mr. George had complied with the province’s Framework for Action Against Family Violence, which had been in place since 1995.

### **Chronology of Events<sup>353</sup>**

In August of 1998, the RCMP detachment in Canso reported to the Children’s Aid Society of Cape Breton that they had intervened in a dispute between Ms. Maxwell and Mr. George. There were inconsistencies in Ms. Maxwell’s report to the RCMP, reporting that Mr. George had dragged her by the hair to the car, and alternatively that he had grabbed her by the throat. She also reported fear that Mr. George might harm her son. The RCMP reported no injuries to her and described her as under the influence. No charges were laid. The police report noted that Mr. George had threatened to kill himself. It appears that the RCMP identified Mr. George as a person of interest related to weapons on Canadian Police Information Centre (CPIC) around this time.

Three days later, Mr. George admitted to a children’s aid worker that he had in fact assaulted Ms. Maxwell. Ms. Maxwell’s two children were removed from her care because of concerns about her continued alcohol and drug use and concerns about Mr. George, who had been convicted of assaulting his oldest daughter in 1997. The children were placed with a family member.

The family moved to Truro in October 1998. Ms. Maxwell’s five-year-old son was returned to her care soon thereafter. Between December 1998 and June 1999, Truro Police Service responded to four calls, three of which related to verbal arguments. The fourth call, on April 10, 1999, was from Ms. Maxwell, asking police to remove Mr. George because he had hit her 5-year-old son the previous day. Ms. Maxwell denied saying this when police arrived. The officers did not interview the child or follow protocols regarding allegations of violence toward children, despite Mr. Maxwell’s previous conviction for assaulting his daughter.

On June 18, 1999, a neighbour called to report that the child had sought his help because of a domestic violence situation. Officers arrested Mr. George and charged him with assaulting Ms. Maxwell, striking her several times in the face and head in the presence of her son. The officers complied with the relevant protocols, notified Children’s Aid, and provided Victim Services support and follow-up support to Ms. Maxwell. Mr. George was released under an undertaking that prohibited him from contacting Ms. Maxwell. That term was varied a week later at the request of Ms. Maxwell.

Over the next several months, police received numerous calls to the home. On three of these occasions, the files were identified as “disturb peace” or “public assistance” calls rather than domestic violence calls. These files did not involve findings of physical violence by police.

On July 24, 1999, Ms. Maxwell called police and reported that Mr. George was threatening her. At the same time, Mr. George was on the phone with police asking them to remove Ms. Maxwell from the home. Officers transported Ms. Maxwell and her son, daughter, and Mr. George’s

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<sup>353</sup> This chronology was established from review of the various reports. Where specifically indicated, some facts were identified from contemporaneous media reports. The report from Correctional Services provided some facts but was otherwise not relevant to the mandate of the Commission and is not summarized here.

daughter to a transition house. Police advised Ms. Maxwell and Mr. George to get counselling. The officers failed to document the information regarding the allegations of threats, to use the domestic violence checklist, or to obtain any statements. There was no record of a CPIC check or consideration of referrals to Children's Aid.

In October 1999, Mr. George called 911 and reported that Ms. Maxwell had assaulted him, causing injuries on his head and hand. Ms. Maxwell was arrested and charged with assault. Police followed the relevant protocols. Ms. Maxwell was convicted in December 1999, to be sentenced in March 2000.

On January 18, 2000, Ms. Maxwell called police to report that Mr. George had hurt his daughter's arm. Police records for this incident were very poor. The police did not document any information regarding the injury, did not complete the Domestic Violence Checklist, and did not follow protocols for child abuse allegations. Mr. George was not charged.

On February 2, 2000, Mr. George pleaded guilty to assaulting Ms. Maxwell in connection with the June 1999 charge. He received a conditional discharge and twelve months of probation. The presentence report noted that Mr. George's ex-wife (not Ms. Maxwell) had reported that he had physically abused her and was controlling. It also noted that Ms. Maxwell had reported that she had ended the relationship but that Mr. George was not taking the separation well. The terms of the probation order did not prohibit contact between Mr. George and Ms. Maxwell and did not restrict his possession of weapons.

On February 5, 2000, Ms. Maxwell called police to report that Mr. George was calling her "day and night." An officer asked Mr. George to stop calling Ms. Maxwell.

On February 10, 2000, Mr. George complained to police that there were drug dealers on his property. The officers learned that Ms. Maxwell was paying rent to Mr. George to stay on the property with his daughter and her son. Mr. George was living in a motel. Ms. Maxwell told police that Mr. George wanted to get back together with her, and she did not want to and hoped to move at the end of the month.

On February 22, 2000, Ms. Maxwell reported that Mr. Maxwell continuously phoned her, had said he was going to come to her place after work, and had been making threats. Police overheard part of a conversation between Mr. George and his daughter, who was with Ms. Maxwell, and did not hear any threats. They observed Ms. Maxwell's address for 45 minutes and checked Mr. George's address, where they observed his vehicle. Police did not use the domestic violence checklist or take any statements. The investigating officer told the reviewers that he was aware that there had been previous calls from this family, but he had not dealt with them before. He was not aware that Mr. George owned firearms. He strongly advised Ms. Maxwell to apply for a peace bond and gave her contact information for a domestic violence worker. He also referred her to the Victim Services Coordinator.

On February 25, 2000, Mr. George's daughter reported that Mr. George had kicked in the door to his home, where she and Ms. Maxwell were living. He did not enter the house. He also called the home repeatedly that day, demanding that they be out of the house by the end of the month. The investigating officer urged Ms. Maxwell to get a peace bond as soon as possible. She promised to do so that day. The investigating officer did not use the domestic violence checklist, take any statements, interview Mr. George, or refer the matter to any agency. He told reviewers that he was aware of the incident that led to Ms. Maxwell being charged with assault and was aware of the standard operating procedure (SOP) on Family Violence. The record was marked as relating

to “property damage” rather than domestic violence. That same day, February 25, 2000, which was a Friday, Ms. Maxwell applied for and was granted a peace bond. In her statement in support of the application, she stated that Mr. George had threatened to kill her and threatened to kill himself. The peace bond was processed by Court Services, and the summons was prepared and ready for the Truro police at noon on Monday, February 28, 2000.

On February 28, 2000, at 11:10 AM, Mr. George called police to report that Ms. Maxwell had caused extensive damage to the property. The officers who attended noted that they had “cleared” the call at 11:40 AM and that they did not note any damage at the property. They did not take any statements, make any referrals, and did not properly document the incident. Later that day, Mr. George called his probation officer, who had advised him earlier that month not to try to reconcile with Ms. Maxwell. Mr. George was very angry at Ms. Maxwell because of the state of the home and said all the counselling he did was pointless. He said that if Ms. Maxwell showed up, he would “tear her head off.” Ms. Maxwell entered the home at that point, and Mr. George yelled at her to get out or he would tear her head off. The probation officer, who was still on the phone, asked to speak with Ms. Maxwell. He told her that Mr. George was in a rage and that she should leave. She refused, saying she had paid rent to the end of the month and had the right to be there. She sounded calm. The line then went dead. The probation officer called Truro Police Service, who went to the home. According to a media report,<sup>354</sup> before the police arrived, a locksmith who had been changing the locks in the home returned after getting lunch. He found Ms. Maxwell covered in blood, trying to get up the basement stairs. Mr. George appeared with a shotgun and tried to shoot the locksmith, who escaped. A neighbour came over, and Mr. George brandished a rifle and told him to get out; the neighbour ran and told his wife to call 911. Mr. George shot Ms. Maxwell and then called 911 before shooting himself. Police arrived and found Mr. George and Ms. Maxwell dead in the home. The children were in school at the time.

The autopsy reportedly concluded that Mr. George had stabbed her seven times in the kitchen and then dragged her to the basement and shot her in the head.

### **PPSSD Truro Police Service Program Review**

The Truro Police Service Review was conducted by the Police and Public Safety Services Division (PPSSD) of the Department of Justice. The reviewers examined the files and spoke to police officers regarding each of the calls to police relating to the family. They also examined whether members of the Truro Police Service had complied with the provincial standard on relationship violence.<sup>355</sup> The reviewers made the following observations:

6. There was consistently poor documentation of occurrences, which affected the ability to supervise the investigative process, allowed for duplication of investigative steps and limited the ability to successfully prosecute offenders.
7. The police responded in appropriate timeframes each time they were called.

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<sup>354</sup> Steve Proctor, “Couple couldn’t escape the past” Halifax Herald, April 16, 2000. This document appears in Relativity in COMM0001251 at 213 – 226. None of the reviews of this matter referred to the involvement of the locksmith or neighbour, or any specifics of the manner of death of Ms. Maxwell and Mr. George other than by shooting.

<sup>355</sup> The Report describes this standard as having been produced by the Police and Public Safety Services Division in conjunction with the Family Violence Initiative of the Province of Nova Scotia. The website of the Nova Scotia government contains a page listing “Policing Standards in Nova Scotia.” There is no “relationship violence standard” listed on this page.

8. Police did not always take victim/offender statements when warranted.
9. In several instances, police did not seek additional evidence such as photographs or witness statements; however, in other instances they did, particularly when there was evidence to support charges.
10. Police made referrals to Victim Services coordinators, Children's Aid workers, and other social agencies in several instances.
11. Sixteen different officers interacted with Ms. Maxwell and Mr. George throughout this fifteen-month period, with "little or no coordination of investigative efforts by supervisory personnel"; the supervision of files was "limited or non-existent in most cases."<sup>356</sup>
12. There was nothing done to capture the frequency of complaints involving Ms. Maxwell and Mr. George, and dispatch personnel were unable to advise responding officers of the history of past intimate partner violence, as they were required to do under the standard operating procedure. Officers told the reviewers that they were uncertain whether or not CPIC checks were done and assumed dispatchers had conducted these checks. None of the officers were aware that Mr. George had been designated as a Firearms Interest Person, which appeared on his CPIC record (apparently placed there by the Canso RCMP). The reviewers noted, "This lack of historical information contributed significantly to the police dealing individually with each domestic complaint as it occurred, as opposed to addressing the totality of interactions with these individuals."<sup>357</sup>
13. On many occasions, responding officers took steps to diffuse the situation and provide a safer environment. Twice, Mr. George asked officers to take his firearms for safekeeping, because he feared Ms. Maxwell would sell or lose them before he could return to the house to retrieve his belongings. Police told the reviewers there were no criminal grounds to seize the weapons because Mr. George did not use them during the altercations leading to police involvement. None of the officers considered applying for an order under the *Firearms Act*, because the firearms played no role in the altercations.
14. Not all officers were following the Standard Operating Procedures for family violence. Truro Police members had been trained on the SOP and the province's Family Violence Initiative in the fall of 1996 through a provincially mandated training program, but that training had not been repeated for officers hired after 1996.
15. The police service as a whole did not investigate verbal arguments in the same way they investigated incidents of violence. The reviewers concluded that this undermines the police response to family violence. "All calls for service that are domestic in nature, regardless of how minor they seem, must be fully investigated utilizing the full resources of the community in order to combat this widespread societal problem."<sup>358</sup>
16. There was no investigative case management system at any level within the Truro Police Service. No one ensured that staff adhered to the family violence protocol. The reviewers noted:

An effective case management system should allow managers to readily identify community crime trends, as well as high risk situations requiring a managed approach. The

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<sup>356</sup> "Truro Police Service Program Review," p. 3.

<sup>357</sup> "Truro Police Service Program Review," p. 4.

<sup>358</sup> "Truro Police Service Program Review," p. 5.

agency did not consider bringing together in-house staff and/or community agencies in an effort to create a strategy for a collective approach to the Maxwell/George situation.<sup>359</sup>

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

- Senior Management develop a strategic training plan for the Truro Police Service, which addresses supervisory training for newly promoted officers and orientation training for newly hired officers, with particular emphasis on family violence training (Nova Scotia Protocol Model).
  - a. Truro Police Service take immediate steps to introduce remedial training as it pertains to conducting preliminary investigations and the documenting of investigational efforts.
  - b. Truro Police Service take immediate steps to train all sworn personnel in investigative case management, with special emphasis on the roles of the case supervisor and case manager.
  - c. Truro Police Service implement Firearms Legislation Training for all members.
  - d. Truro Police Service ensure that investigating officers conduct all appropriate CPIC and in-house queries related to assigned investigations and ensure these queries are recorded on the investigative file.
- Truro Police Service ensure dispatch personnel have access to all previous family violence/domestic disturbance history, and this information is relayed to responding officers.
- Supervisors ensure all police responses to Family Violence/Domestic Disturbance adhere to Standard Operational Procedure, Part II, Chapter 8.
- Supervisors ensure Domestic Violence Checklists are utilized in all cases of Family Violence/Domestic Disturbance Calls.
- The manager responsible for case management should track repeated instances of individual Family Violence/Domestic Disturbances cases, with the view of developing a departmental and community strategy for the effective management of high-risk cases.
- Truro Police Service review policy regarding the recording and documenting of all criminal occurrences and ensure uniformed [sic] compliance to the policy by all members.

### **Department of Community Services Review<sup>360</sup>**

This review examined the involvement with Ms. Maxwell and Mr. George of each service provider funded through the Department of Community Services in Truro and in other parts of Nova Scotia. Ms. Maxwell was involved with child protection services prior to her relationship with Mr. George, due to cocaine addiction. Following Mr. George's arrest for assaulting Ms. George in June 1999, he self-referred to Bridges, a men's intervention program in Truro. He had "extensive" involvement with Bridges over the next several months.

The Review identified problems with the child protection agencies' interactions with the family. It did not identify issues with respect to Bridges or Victims Services' interactions with the family.

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<sup>359</sup> "Truro Police Service Program Review," p. 5.

<sup>360</sup> "Maxwell/George Case Review," Nova Scotia Department of Community Services (October 2000).

### Recommendations Relevant to the Mandate of the Mass Casualty Commission

1. A coordinated response be implemented to address family violence. At the community level this means all agencies, government and non-government, must develop coordinated policies and procedures that remove structural and systems barriers.
2. Existing protocols be reviewed and revised to ensure that they incorporate co-ordinated, effective interventions to ensure the safety of children and women. The need for the development of any additional protocols should also be assessed.
3. All barriers to information-sharing between and among agencies and government offices be identified and procedures be developed to address them.
4. The Department of Community Services immediately undertake training in the following areas:
  - Protocols related to family violence and include participation of other relevant departments and service providers.

### Department of Justice Review of Compliance with the Framework for Action Against Family Violence<sup>361</sup>

The Framework for Action Against Family Violence contained a police protocol, which the Police and Public Safety Services Division had incorporated into a Standard Operating Procedure to be followed by all municipal police forces. The Justice Sector review concluded that other than the two instances where charges were laid, the police did not consistently apply the Framework's protocol. It echoed the findings of the PPSSD review (above) that there was no indication that police supervisors provided any effective coordination or oversight of the files involving Ms. Maxwell and Mr. George. There were also no meaningful file reviews or assessment of the frequency of the alleged incidents of family violence. Officers diffused the situations but did not conduct full investigations and, in some cases, failed to make appropriate referrals, as required by law, to child protection authorities or referrals to social agencies, as required by the Standard Operating Procedure.

The Department of Justice review concluded that the events leading up to the deaths “seemed to be a textbook case of escalating and persistent family violence.” It noted the importance, as set out in the Framework, of a coordinated approach to family violence matters and concluded, “There is no indication that any of the components involved in this review ever individually or collectively attempted to initiate a multidisciplinary solution to the complaints of family violence from Ms. Maxwell, Mr. George, and their children.”<sup>362</sup>

### Recommendations Relevant to the Mandate of the Mass Casualty Commission

- A. The Minister of Justice should direct PPSSD to immediately conduct a full and comprehensive audit of the Truro Police Service, with special attention to family violence investigations and case management practices. The resulting recommendations from PPSSD would have to be implemented by Truro Police Service within a reasonable timeframe, failing which a Notice of Noncompliance pursuant to subsection 12(3) of the Police Act could be issued. Additional

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<sup>361</sup> “Program Review into the Deaths of Lori Lee Maxwell and Bruce Allen George (February 28, 2000),” Nova Scotia Department of Justice (September 2000).

<sup>362</sup> “Review into the Deaths of Maxwell and George,” p. 10.

Framework for Action and Firearms Act training for all members of Truro Police Service should be ordered, along with training in the area of child abuse protocols.

- B. In conjunction with a comprehensive audit of Truro Police Service, the Minister should direct PPSSD to conduct an assessment of municipal police services to determine if the same problems identified in this report exist elsewhere. The logistics of this assessment would have to be coordinated with the Executive Director of the PPSSD.
- C. With respect to the lack of Interagency Coordination, each component should formulate a policy, in consultation with the other components, outlining when it would be appropriate to initiate interagency coordination in a family violence situation, how to initiate contact, and establish a protocol for appropriate information-gathering and sharing.
- D. Although the Report, with the exception of Truro police and recommendation #3 above, concludes that the justice components acted in accordance with the Framework for Action, we are of the view that the fact that this tragedy occurred makes it incumbent upon all relevant components of government to review their family violence policies to determine whether they can be improved or enhanced based upon the lessons we have learned from these deaths. With this in mind and recognizing that not all deaths will be prevented regardless of government policies, we suggest that someone familiar with family violence review the Framework for Action to determine whether it can be improved.<sup>363</sup>

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### **6.1.5. Review of the Framework for Action Against Family Violence (“Russell Report”) (2001)<sup>364</sup>**

The Nova Scotia Framework for Action Against Family Violence was the subject of a review in 1999<sup>365</sup> a copy of which was not available at the time this scan was prepared. Then, following the George/Maxwell murder-suicide, the Minister of Justice commissioned Dawn Russell, then Dean of Dalhousie University Law School (and a member of the Law Reform Commission when it released “From Rhetoric to Reality,” summarized above in section 6.1.3.), and Diana Ginn, Assistant Professor of Law, to conduct a further review. It was completed in 2001 and is commonly referred to as the “Russell Review.”

Dean Russell and Professor Ginn reviewed the approaches to family violence of other Canadian jurisdictions and conducted a literature review to identify jurisdictions with policies similar to the Framework for Action and to identify new developments since the Framework was introduced. They also held focus groups with or received submissions from RCMP and municipal police officers, police management, provincial court judges, victims, the Nova Scotia Advisory Council on the Status of Women, Crown attorneys, the Public Prosecution Service, transition houses, men’s intervention groups, Victims’ Services, children’s aid societies, and other violence against women (VAW) and community-based organizations.

The Framework required police to “respond to and fully investigate all family violence cases, gathering as much evidence as possible at the scene to reduce reliance on victim testimony”<sup>366</sup>

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<sup>363</sup> This subsequent review, known as the “Russell Review,” is summarized below in section 6.1.5.

<sup>364</sup> “Framework for Action Against Family Violence: 2001 Review” (“Russell Report”), submitted to the Department of Justice of Nova Scotia (May 2001), <https://novascotia.ca/just/publications/docs/russell/TOC.htm>.

<sup>365</sup> Nova Scotia, “Implementation of the Framework for Action on Family Violence” (April 1999). This document appears as Appendix B to the Russell Report, above. See COMM0001034.

<sup>366</sup> “Russell Report,” p. 18.

and where reasonable and probable grounds exist, charge, arrest and remove the alleged perpetrator from the home irrespective of the victim's wishes. The Russell report noted that some police officers had failed to appreciate or accept the obligation to assess reasonable and probable grounds. There were wide variations in attitude and approach to victims, an increase in cross-charging, and uncertainty as to how to deal with difficult cases. There were also some problems with police auditing, and the intensive training delivered to 3000 justice workers in 1997 after the launch of the Framework had not been repeated. The Framework also required the Minister of Justice to direct RCMP subdivisions and municipal police forces of 60 or more officers to create family crime units. However, the Minister had not issued this directive.

The Russell Report noted that the Framework for Action called for improved collaboration and cooperation among all organizations and individuals with a role to play in responding to domestic violence. The Family Violence Prevention Initiative (FVPI) was responsible for the overall coordination of these efforts, but it was eliminated in 2000. The elimination of the FVPI made interagency cooperation more difficult and less likely to occur. Cuts to funding that had earlier been provided by the province to facilitate and support interagency coordination had also had a significant impact on interagency cooperation.

The Russell Report noted that the Framework had required each justice agency to monitor its compliance with the Framework through a structured audit mechanism, including mandatory reporting of each instance where a charge was not laid or was later withdrawn, with reasons. The monitoring would also require information on victim satisfaction, and there was to be a tracking system to permit ongoing monitoring of cases. This information was to be provided to the FVPI. The Report noted that police monitoring was ongoing, but Crowns, courts, and corrections officers had not implemented an auditing system, and, as noted above, the FVPI had been disbanded in 2000.

The Russell Report also identified gaps in the Framework, including a lack of focus on the particular context of Indigenous victims and on the difficulty that victims have in leaving their homes and navigating family court processes.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Chapter 1) That Nova Scotia develop a strategy for delivering an ongoing training program for police and other justice workers, using and building on the successful training done immediately following the implementation of the Framework. The training should address all of the issues dealt with in the original training program and the inconsistencies and difficulties identified in this Report. Participants from all justice sectors and from community organizations should be involved in its development and delivery.
2. (Chapter 1) That in metropolitan areas where the number of domestic violence incidents reported annually justifies it and the size of the police force permits it, RCMP subdivisions and municipal police forces dedicate resources to the establishment of a specialized domestic violence investigative unit. It is also recommended that a process or mechanism be established for each municipality in the Province to do the thorough investigation and follow-up required in difficult cases. This mechanism might include a single specialized domestic violence police investigator within each municipality or, in the case of smaller municipalities, a special domestic violence investigator shared between adjoining municipalities. Each municipality should also have within its police force a crime prevention victims' services coordinator.

3. (Chapter 1) That police seek legal advice from Crown prosecutors in difficult cases, particularly where there are mutual allegations. It is also recommended that consideration be given to the adoption of a primary aggressor policy requiring officers to determine and arrest the primary aggressor in the incident, thus reducing the likelihood of cross-charges.
4. (Chapter 1) That police procedures within each department or detachment be reviewed to ensure that both victims and Victims' Services are informed regarding interim release.
5. (Chapter 1) That auditing be improved, specifically in terms of the carry-through from the individual domestic violence incident to the larger case file. This carry-through process should be overseen by the case supervisor responsible for noting discrepancies in recordkeeping and in compliance with the Framework. Police should document domestic dispute calls as carefully as they document intimate partner violence incidents, since both are a critical part of the history of family violence in a particular case.
6. (Recommendation 2.1) It is recommended that the primary justice system response to intimate partner violence should be to treat it for what it is: criminal activity deserving of sanctions from the criminal justice system. Furthermore, it is recognized that simply allowing wishes expressed by the victim to dictate whether or not a particular charge proceeds would be a retrograde step, providing perpetrators with an opportunity to coerce victims into asking for stays. Thus, even if some flexibility might be introduced (as discussed below in the portion on diversion), a pro-charge, pro-prosecution philosophy should remain the cornerstone of the Framework. The goal must then be to translate this philosophy into securing convictions where a crime has occurred and enhancing victim satisfaction with the process.
7. (Recommendation 5.1) That the Department of Justice enter into discussions with those within the Department charged with implementation of the Framework, other government departments, and the community, in order to determine the most appropriate and efficient ways of delivering the services needed for full victim support, and it is recommended that the government commit sufficient funding to allow for such delivery.
8. (Recommendation 5.2) It is recommended that the Family Violence Prevention Initiative be reinstated.
9. (Recommendation 6.0) It is recommended that Nova Scotia develop and implement ongoing training for all justice sectors, building on the initial success of the train-the-trainer model used following the implementation of the Framework, involving community agencies early on in both the development and delivery.
10. (Recommendation 7.1) It is recommended that the Minister of Justice require the Public Prosecution Service, Courts and Registries, and Correctional Services to formally restate their commitment to the Framework for Action Against Family Violence and require them, within six months of their restatement, to articulate the means by which they will monitor adherence to the Framework. It is also recommended that the unimplemented prototype information system built by the Province to collect data on an ongoing basis to track the progress of the justice system with respect to domestic violence cases be reviewed and, if at all possible, that it be implemented.
11. (Recommendation 8.1) It is recommended that the Province support and strengthen, with senior level commitment, the coordination of family violence activities within and external to the Department of Justice, involving both government and community stakeholders.
12. (Recommendation 8.2) It is recommended that existing interagency protocols among police, child welfare, transition houses, Corrections and men's treatment programs be reviewed and that, where required, new interagency protocols be developed and confidentiality agreements

concluded to facilitate the sharing of information necessary to protect and support victims and their children.

13. (Recommendations 9.3) It is recommended that the reluctance of victims living in Aboriginal communities and from visible minorities to report spousal or partner violence be addressed in the training program developed for justice workers.
14. (Recommendation 9.4) Victims of perpetrators from Aboriginal communities and racial minorities sometimes feel that reporting their batterers to police is a breach of loyalty to the community and are also concerned that it will contribute to racial/cultural stereotyping. Such concerns may be alleviated in part by increased reliance on evidence other than victim testimony. It is recommended that this be done wherever possible.
15. (Recommendation 9.5) As well, insofar as evidence suggests that advocacy services can assist victims in finding the strength to escape domestic violence on their own and can help to amplify their voices to enable prosecution policies to be applied in a way that meets the needs of particular victims, it is recommended that Nova Scotia invest in expansion of support services for abused women, including advocacy services to provide outreach and support for women from Aboriginal communities and visible minorities.
16. (Recommendation 10.0) It is recommended that Nova Scotia maintain and expand its initiatives in public education. Such initiatives should assist in identifying behaviours that are abusive, providing information on services available to victims and their families, and increasing public understanding of the fact that intimate partner violence will not be tolerated. Components of the public education message would need to be tailored, both in terms of the specific content and the medium used to convey it, in order to reach various groups within society, including those already in or at risk of entering abusive relationships.
17. (Recommendation 11.1) It is recommended that Nova Scotia consider adopting domestic violence legislation as a supplement to the Framework for Action, which should likely include provisions allowing victims the exclusive occupation of the home, temporary care and custody of the children, and a specific prohibition against selling, converting, or damaging property. Provisions directing removal of the abuser and seizure of weapons are also important.
18. (Recommendation 11.2) In the event that such legislation is adopted in Nova Scotia, it is recommended that training be conducted well in advance of the introduction of the legislation and it include: (1) the dynamics of family violence; (2) the Framework policies and procedures and application of the Criminal Code; and (3) the elements of the civil legislation. It is recommended that coordination and monitoring occur at both the local and provincial levels through interagency committees and that, if implemented, the legislation be monitored through ongoing data collection and that it be evaluated within five years of its introduction. Public education should also accompany the legislation to ensure the victims and the community are aware of it. Issues pertaining to the application of the legislation on reserves should be addressed in consultation with Aboriginal communities.

### **Implementation of the Recommendations**

Between 2001 and 2003, the government took the following steps in response to the Russell report:

1. Introduction of the Domestic Violence Intervention Act, which allowed for emergency protection orders and came into effect in 2003 (summarized below in section 6.1.6.)

2. Creation of a Justice Learning Centre in Truro, in partnership with the Nova Scotia Community College, to provide ongoing training for justice personnel
3. Creation of the Deputy Minister's Leadership Committee on Family Violence
4. Creation of the Police Domestic Violence Case Coordinator Program, a province-wide program to enhance police capacity in coordinated case management (identifying high-risk situations, information-sharing, and referrals)
5. Development of a High-Risk Case Coordination Protocol Framework for Spousal/Intimate Partner Violence
6. Amendments to the Framework

Other initiatives between 2004 and 2009 include:

- Adoption of a Danger Assessment Tool developed by Dr. Jacquelyn Campbell (in 2004)
- Establishment of the Family Violence Tracking Project (2004)
- Issuance of a Police Pocket Guide (2005), which includes risk assessment for intimate partner violence
- Establishment of a risk assessment tool committee in 2005 to evaluate the Ontario Domestic Assault Risk Assessment (ODARA); subsequent adoption of the ODARA for use in Nova Scotia in 2008
- Creation of a joint government–community Domestic Violence Prevention Committee in 2008.

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### **6.1.6. Evaluation of the Nova Scotia Domestic Violence Intervention Act (Department of Justice, 2006)<sup>367</sup>**

Nova Scotia enacted the Domestic Violence Intervention Act (DVIA)<sup>368</sup> in 2003 in response to the Maxwell/George murder/suicide (see above section 6.1.4.) and the recommendations of the resulting review of the Framework for Action Against Family Violence in 2001 (the “Russell Review”) (summarized above in section 6.1.5.). The Nova Scotia Department of Justice commissioned this evaluation two years after the DVIA came into effect in order to evaluate its overall effectiveness and identify any unintended consequences. The authors of the report reviewed data relating to the DVIA, conducted interviews and focus groups with victims, police, transition house staff, victim services staff, and other stakeholders. They also conducted three surveys with additional stakeholders, including domestic violence case coordinators, DVIA trainers, and child protection workers.

The DVIA permits victims of intimate partner violence, or a person acting on their behalf, to apply for and obtain a 30-day emergency protection order (EPO). The EPO can be extended to a total of 60 days. The application is heard by Justice of the Peace over the phone and can be heard at

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<sup>367</sup> Barbara Herring and Associates, “Evaluation of the Nova Scotia Domestic Violence Intervention Act”, prepared for the Department of Justice, Province of Nova Scotia (March 2006). This document is available in Relativity at COMM0001041.

<sup>368</sup> Domestic Violence Intervention Act, SNS 2001, c. 29, <https://nslegislature.ca/sites/default/files/legc/statutes/domestic%20violence%20intervention.pdf>.

any time. The applicant does not need to give notice to the respondent, and the order will be binding on the respondent once that person receives notice of the order. The Act sets out conditions that can be attached to the order, including conditions to give the applicant exclusive possession of the home, temporary care of the children, and control over finances. The order can also prohibit the respondent from having contact with the applicant or other people or from attending at specific places. It can also give police the power to remove the respondent from the home or seize weapons.<sup>369</sup> The JP hearing the application must fill out a checklist (provided for in the regulations to the DVIA)<sup>370</sup> and must consider the nature and history of intimate partner violence, whether the applicant could wait until the next court sitting to obtain the order, and other factors. Once an EPO is granted, a judge of the Nova Scotia Supreme Court must review the order and determine whether to confirm, vary, or terminate it, or whether to hold a hearing. The applicant or respondent can also seek a hearing in the Supreme Court to vary or terminate the order. Breach of the order carries with it a maximum penalty of three months' imprisonment and/or a \$5000 fine for a first offence. Second or subsequent breaches have a maximum penalty of two years' imprisonment and/or a \$10,000 fine. The same penalties apply if a person is found to have falsely and maliciously applied for an order.

The DVIA defines domestic violence in terms of physical assaults, threatened or actual acts or omissions that cause a reasonable fear of bodily harm and damage to property, forced confinement, actual or threatened sexual assault, exploitation or molestation, or "a series of acts that collectively causes the victim to fear for his or her safety, including following, contacting, communicating with, observing, or recording any person."

The reviewers found that overall, the DVIA had been successful. Victims felt safer and appeared to in fact be safer with an EPO in place. They also felt more empowered and heard. Police were generally advising victims of the option to seek an EPO and referring them to a transition house or victim services. Police often encouraged victims to seek an EPO even where they laid charges and there were similar conditions for release, in order to give the victim added protection. They also encouraged them where police did not have sufficient evidence to lay a charge.

Most orders were served within one day. 59% of applications were granted, and the vast majority of those (91%) were confirmed by the Supreme Court review.

However, the reviewers found that the denial of an application could be devastating for victims. Transition house workers therefore only sought EPOs where they believed they were likely to be successful. The reviewers also found that the way JPs responded when denying an order "can be as damaging as the denial itself."<sup>371</sup> People reported cases in which JPs yelled at applicants who were consumers of mental health services and other instances of insensitivity toward the applicants. The reviewers also noted concerns reported by police that a person served with an EPO could become agitated, leading to more violence. About half of the stakeholders believed that the DVIA was helping to address the societal impacts of intimate partner violence. Others did not, in part because breaches carried such mild penalties.

The authors also found that JPs did not consider threats without physical violence, or emotional abuse, when considering EPO applications. They recommended that emotional and

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<sup>369</sup> There is no provision in the DVIA permitting police officers to search for weapons. However, the DVIA does allow an EPO to "do any other thing that the justice considers necessary to ensure the immediate protection of the victim or any child." (s.8(1)(l)).

<sup>370</sup> "Domestic Violence Intervention Act: Justice of the Peace Emergency Protection Order Application Checklist," .

<sup>371</sup> "Evaluation of the Nova Scotia Domestic Violence Intervention Act", p. 14.

psychological abuse be included as grounds for an EPO, as well as threats to kidnap or harm a child.

The reviewers found some issues with the checklists JPs were required to fill out. The JPs they spoke with suggested that the checklist should be changed to set out the risk factors the JP should consider, which would focus the JP's attention on the danger facing the applicant. Stakeholders reported that there was significant variation among JPs as to whether or not they would issue an EPO and little rationale provided by the JPs of their decisions.

The report noted the extent to which the JPs relied on their telephone interview with the applicant to determine whether to grant the EPO. Although the Department of Justice advised the reviewers that the intention of the DVIA had been to allow transition house or other designated applicants acting on behalf of the victim to give evidence, in practice the JPs wished to hear only from the victim. Transition house staff told the reviewers that victims are in a very vulnerable state when they apply for EPOs. They may have trouble focusing and presenting their information clearly and completely and may minimize the abuse out of embarrassment or because they feel safe at the time. JPs did not ask specific questions, such as whether the perpetrator has weapons, and women may leave out such crucial information. Where victims have mental or emotional disabilities, transition house staff will generally not encourage her to apply for an EPO because they believe she will not be able to convey the required information to the JP. The reviewers noted that this apparent bias toward victims who are articulate and refusal to hear from anyone other than the victim have implications for members of immigrant and Indigenous communities as well as people with disabilities. The reviewers recommended that the use of designates to provide information to the JP be reviewed.

The reviewers noted other challenges for victims from Indigenous, Black, and immigrant communities. These included lack of awareness of the DVIA, fear of interacting with the justice system, fear of being ostracized from their husbands' families should they seek an EPO, fear of deportation if their husbands refuse to continue sponsoring them, and a reluctance to expose the abusers to criminal consequences for breaching the order. The reviewers also noted concerns regarding cultural differences in the use of courts for "family" matters, lack of diversity among frontline agency staff, language barriers, which make it difficult for women to apply for and obtain EPOs, and concern that interpreters may be from the same community as the abuser. There was also uncertainty about whether EPOs granted under the DVIA would be enforceable on First Nation lands. Some people also suggested that stakeholders should be trained on the context and conditions of violence in gay and lesbian communities.

Stakeholders were very critical of the penalties for breach. They were of the view that these penalties were lighter than those for breaching of an undertaking. Police officers reported issues with pursuing breaches aggressively because the penalties were so light. Statistics showed that out of 30 charges for violating an EPO in the period 2003–05, fourteen were dismissed, ten were withdrawn, and six resulted in a sentence. There was an increase in charges and in sentences from the first to the second year.

Some peace officers, Crowns, and child protection workers said they believe people apply for EPOs dishonestly, particularly where there is a custody dispute, as a way to get an order they would not otherwise be able to obtain. (EPO conditions relating to custody prevail over other custody orders, except those issued in a child protection proceeding.) Transition house staff were of the view that this is rare and pointed out that applying for an EPO is draining and time-consuming. The reviewers thought there might be some benefit for JPs obtaining corroborating information, such as police records, information from transition houses and victim services, and

custody proceeding records. However, they noted that this would likely delay the decisions by JPs, which would be a significant negative consequence.

Most of the Crown prosecutors in Halifax said they believed the DVIA is unconstitutional because the orders are made without notice to the respondent. There had been three Charter challenges brought against the DVIA, which were abandoned. They also said that it was difficult to prosecute breaches because the DVIA is civil legislation, because orders are granted without notice, and because the underlying IPV incident has not been proven in court. For the same reasons, it was difficult to justify detaining a person charged with a breach of an EPO. Other Crowns and other legal staff did not express concern about prosecuting these breaches and pointed out that some family court orders are also made without notice to the respondents.

Because only Supreme Court judges can vary an EPO, it is difficult for victims to add conditions because of a change in circumstances or correct an error in the order. Some Crowns were also concerned that the provisions of the DVIA that allow a JP to deem that an EPO had been served—and therefore deemed effective—where the respondent appeared to be evading service may also be unconstitutional.

The review did not find that the fact that JPs are required to inform child protection authorities in cases where they believe a child is at risk was a deterrent to women seeking orders. Child protection workers reported that EPOs add a little to children's safety. The reviewers found that more awareness is needed for child protection workers and for the public about the DVIA. There were also concerns about whether JPs should report an applicant's allegations of violence to police (where there are no concerns about the welfare of a child). Police and Crowns were in favour of this practice, while others believed it would discourage women who did not want to become involved in the criminal justice system from using the DVIA as an alternative response to IPV.

Stakeholders reported difficulties getting extensions for EPOs, which can only be granted by Supreme Court judges. The process is confusing, and they are rarely granted. One victim services worker told the reviewer that JPs will grant an extension "if they believe the woman has 'tried hard enough,' but if she is in trauma, it may be hard for her to do things this fast."<sup>372</sup> Stakeholders also expressed frustration that hearing dates were sometimes unavailable until after the 60 days had expired, particularly in outlying regions and in the summer. That left women without orders to protect them. Respondents can seek adjournments of the hearing, which has the effect of running out the order.

There was consensus that there needs to be much more public education about the availability of EPOs. Only those victims of IPV who were in contact with specific service providers appeared to be aware of it. Funding for transition houses, which are the primary support for applicants, had not increased to account for this increase in their workload.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. Amend the DVIA to include the full definition of domestic violence, thereby including emotional and psychological abuse as grounds for an EPO.
2. Amend the DVIA to specifically consider a threat to commit kidnap or harm a child as a situation where an EPO for a relevant adult should be considered.

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<sup>372</sup> "Evaluation of the Nova Scotia Domestic Violence Intervention Act", p. 40.

3. Review the use of designates with representatives of the Transition House Association of Nova Scotia and the other designate groups and with the judiciary. Consider how to meet the judicial requirements of evidence and at the same time ensure that EPO application information is provided fully and effectively.
4. Continue to encourage service providers in Aboriginal, minority, and immigrant communities to recommend use of the DVIA when appropriate and encourage them to participate in finding ways to use its provisions in ways that are appropriate for their communities.
5. With service providers in the immigrant and Aboriginal communities, prepare materials to help victims in these communities understand the usefulness of the current approaches to domestic violence including use of the DVIA.
6. Encourage other stakeholders to seek out information on cultural differences with respect to Aboriginal, minority, and immigrant cultures and help them understand the barriers these groups face in accessing their services.
7. Provide the resources to create materials on domestic violence and the DVIA in the languages most needed by immigrant communities and, if there is a need, in Mi'kmaq and French.
8. Provide information to immigrant communities about the language interpretation provisions for EPO applicants.
9. Consider ways to include service providers serving the Aboriginal, minority, and immigrant communities within a new category of designates, perhaps in partnership with transition houses.
10. Encourage elders and other community leaders in immigrant and Aboriginal communities to learn about the DVIA and support the victim in EPO applications when asked.
11. Discuss with these community leaders other conditions that could be included in an EPO to make it more relevant to immigrant and Aboriginal communities respectively.
12. Hold discussions with immigration officials and with immigrant support organizations to determine how best to mitigate any negative immigration-related consequences on the victim of reporting domestic violence or applying for an EPO.
13. Meet with representatives of the appropriate partners from other jurisdictions to ensure understanding and agreement on how jurisdictional issues with respect to the DVIA on Aboriginal land should be handled.
14. In training about the DVIA, include an awareness and sensitivity to the conditions and culture of gay and lesbian communities.
15. Research the appropriateness of the penalties being awarded for EPOs and take corresponding action if necessary.
16. Communicate to stakeholders the current data on penalties for breaches of EPOs. It would be helpful to provide comparable data on penalties for breaches of court orders in domestic violence situations.
17. Review the legislation to determine if further corroboration is required, particularly with police detachments in the location of the events, transition house and victim services staff if involved, and court records related to custody if the conditions of the EPO include custody.
18. If the department considers it helpful to have more corroborative information, consult with stakeholders and with the judiciary about how this could be incorporated into the EPO process.

19. Encourage an exchange of information between the judiciary and other stakeholders about how to ensure the EPO will be accurate and relevant to the applicant's needs.
20. Provide more information/training for child protection workers about the DVIA and their related responsibilities.
21. Encourage dialogue and co-ordination of efforts among child protection workers, transition house and victim services staff, and the police. Encourage these stakeholders to develop a coordinated response protocol.
22. Encourage an exchange of information between these stakeholders and the judiciary.
23. If the victim is in a transition house (or other safe place), provide an option for the 30-day EPO timeframe to begin once the victim leaves the place of safety.
24. Discuss further with all stakeholders the overall impact of JPs reporting all incidents of domestic violence to the police where the police have not already been notified.
25. If the department decides to encourage JPs to report all instances of domestic violence to the police, consider beginning this change with a pilot project that includes a careful evaluation of outcomes.
26. Ensure that peace officers, transition house staff and victim services staff in particular have thorough and up-to-date information about the DVIA and EPOs since they are the main sources of this information for victims of domestic violence.
27. Encourage JPs and other stakeholders to reinforce to EPO applicants and potential applicants the process in the case of a hearing and the options available.
28. Include information about the DVIA in any public education campaign about domestic violence.
29. Develop public information tools, such as a poster about the DVIA to be distributed by means of stakeholders, other public sector and not-for-profit organizations in conjunction with public education efforts around domestic violence.
30. Encourage the use of the DVIA in conjunction with police involvement and police assessment of the possibility of a charge, while indicating that the DVIA could also be used when no charge has been laid.
31. Provide a forum for representatives of the police, transition houses, victim services, and the judiciary to meet periodically to discuss issues related to application of the DVIA and increase co-ordination of response.
32. Communicate to JPs that other stakeholders observe a need for JPs to have additional education about domestic violence, especially regarding the seriousness of emotional and psychological abuse, sensitivity to the mental/emotional state of victims after an incident, and assessing risk factors.
33. Encourage peace officers to use the Police Pocket Guide on Spousal/Intimate Partner Violence (flip book, June 2005) and include use of the flip book in police training.
34. Develop regular DVIA training for new police recruits and for RCMP officers newly posted to the province, including how to respond to breaches of an EPO.
35. Continue to provide "refresher training" and updates for all stakeholders, particularly for designates. In that training, focus on the following areas:
  - Forms that peace officers and others need to complete;
  - Details of the EPO process;

- Communication related to court hearings;
  - New information about the DVIA, its implementation and how effective it is.
36. Encourage transition houses that have developed training and other support materials related to the DVIA to inform other transition houses of the existence of these materials and facilitate the sharing of these resources.
37. As opportunities arise, provide information and/or training for court staff and lawyers who practice family law.
38. Discuss the DVIA with Crown prosecutors, clarify their role, if any, with respect to this legislation and respond to their concerns where appropriate.
39. Provide transition houses with compensation for the additional time their staff spends in the role of DVIA designates.

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### 6.1.7. Report of the Domestic Violence Prevention Committee (2009)<sup>373</sup>

The Domestic Violence Prevention Committee (DVPC) was created in 2008 by the Ministers of Justice and Community Services. Its mandate was to make recommendations regarding the development of a domestic violence strategy for Nova Scotia, including victim services, prevention and public education, interventions for abusers, and judicial and legislative responses. The DVPC included representatives from the provincial government, women's shelters, men's intervention programs, Mi'kmaq healing centres, police, and sexual assault centres. The Committee also consulted with Acadian, African Nova Scotian, and Aboriginal women, women with disabilities, women involved in the criminal justice system, and rural and immigrant women. The Committee's guiding principles included making decisions using the Feminists for Just and Equitable Public Policy Modified Consensus Model. It defined "intimate partner abuse" to include physical, sexual, mental, emotional, financial, and spiritual abuse. The DVPC submitted the Report to the Deputy Ministers' Leadership Committee on Family Violence in June 2009.

In the introduction to the DVPC report, the authors stated:

In decades of dealing with the effects of domestic violence in Nova Scotia, many tools, programs, and services have been created to address the needs of victims and perpetrators of domestic violence. These programs and services have been supported by both government and community. What has been lacking is an approach that coordinates them to create the continuum of care and support needed to allow those who are affected to make real changes in their lives.<sup>374</sup>

The Report did not refer specifically to the Framework for Action Against Family Violence or any of the previous reports or recommendations. Its recommendations were broad and numerous. It included a list of "overarching recommendations," including making the safety of victims the most important consideration, making collaboration between government and community the standard practice, and ensuring that new and existing programs and supports honour the diversity of the people who need them.

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<sup>373</sup> "Report of the Domestic Violence Prevention Committee," submitted to the Nova Scotia Deputy Ministers' Leadership Committee on Family Violence (June 2009), [https://novascotia.ca/just/global\\_docs/DVPC\\_recommendations.pdf](https://novascotia.ca/just/global_docs/DVPC_recommendations.pdf).

<sup>374</sup> "Report of the Domestic Violence Prevention Committee," p. 4.

### Recommendations Relevant to the Mandate of the Mass Casualty Commission

1. Create, enhance, and sustain services for identifying and addressing domestic violence in the early stages. Make early identification and referral part of a continuum of services for both victims and abusers.
2. Increase capacity to respond to victims of domestic violence. Train health professionals and other first responders, such as 911 operators and volunteer firefighters, to identify and support victims of domestic violence. Train other direct service providers (e.g., providers of supported employment, residential care facilities, etc.) to screen for domestic violence and to provide sensitive and appropriate referrals and support.
3. Ensure that provincial and municipal police agencies commit to domestic violence training on an ongoing basis. This could include coaching in addition to formalized training sessions, to ensure that there is no gap in access to trained and supportive police champions in communities.
4. Develop a framework for applied research through government and community groups to examine issues relating to domestic violence in the province that include:
  - a. The role of alcohol and other drug use/abuse as a contributing factor in domestic violence
  - b. The cost of domestic violence in the provincial economy
  - c. The role that children's advocates could play in Nova Scotia
  - d. Exploration of why sexual violence is under-reported in cases of domestic violence
  - e. The effectiveness of public education campaigns
  - f. The availability of legal aid services to victims of domestic violence
  - g. Effective methodologies for men's intervention programs
  - h. Violence perpetrated in same-sex relationships and on transgendered individuals, to understand their unique needs for prevention and supports
  - i. New ways to screen for domestic violence
  - j. New ways to connect with and serve those who do not use existing services, such as women reluctant to report incidents of domestic violence, male victims, and transgendered individuals
5. Facilitate linkages between governments (provincial, federal and First Nation) and Aboriginal organizations so that the needs of Aboriginal people experiencing domestic violence can be addressed through timely and effective programs and services.
6. Support all victims, whether they live in rural or urban areas, with access to a continuum of domestic violence services that includes:
  - a. A transition house with professionally trained staff, on duty at all times
  - b. Second-stage housing with ongoing counseling support
  - c. Access to crisis services by phone
  - d. Crisis-response services
  - e. Counseling and support for children with follow-up and outreach programs that are available for at least two years
  - f. Extended supervised access visit and exchange programs
  - g. Outreach that is delivered by both community-run and government-run programs
  - h. Community organizations that support women and their families, such as women's centres, family resource centres, sexual assault centres, and other services
  - i. Services that are coordinated for victims whose cases are designated as high risk

- j. Accessible services for victims with disabilities (e.g., safety planning tools that build on existing emergency planning preparedness for persons with a disability or interpretation for victims who are non-verbal)
  - k. Qualified interpreters for language and culture
  - l. Support of holistic models of service delivery, particular to the Aboriginal community
  - m. Services that can identify domestic violence in early stages
7. Recognize the web of social supports that are required to support victims and help them stay safe, such as housing, transportation, income, childcare, and education. These supports should include the following:
    - a. Housing in both rural and urban communities that is affordable and safe. Create second-stage, third-stage, and independent housing with supports. Explore ways to provide off-reserve second- and third-stage housing for Aboriginal victims.
    - b. Programs for parents in life skills and parenting
    - c. Programs in life goal-planning
    - d. Support services to help victims upgrade their education, prepare for work, and move into a career
    - e. Personal supports and services for women with disabilities to maintain their ability to parent and participate in the community
    - f. Replacement of assistive devices damaged or lost through domestic violence
    - g. Access to transportation
    - h. Access to dental care
    - i. Access to affordable childcare
  8. Create community-based navigator positions to support victims who are accessing a variety of systems (for example, employment supports, income assistance, housing, health) that support their move away from abusive relationships.
  9. Develop provincial standards, guidelines, safety planning, referral and monitoring procedures for a victim-centred and comprehensive response to domestic violence in emergency rooms and primary care settings.
  10. Consistently apply and monitor screening tools in public health and primary care settings.
  11. Review how jurisdictional mandates and responsibilities create additional barriers for Aboriginal victims seeking services.
  12. Create and sustain primary prevention programs aimed at preventing domestic violence. These programs should be available to people starting with early childhood and continuing across the life span. These programs should recognize and reflect the social determinants of health, including gender, poverty, employment, and inequality.
  13. Promote collaborative partnerships among government agencies, government departments, and community-based agencies with expertise in domestic violence and prevention and intervention.
  14. Integrate and coordinate domestic violence prevention initiatives across government, including health promotion services, early intervention and childcare services and primary health care services.
  15. Create tools and resources for friends, neighbours, faith communities, and families to support women and children who are experiencing domestic violence.

16. Support Aboriginal and other diverse communities in the development of programs that deal with prevention of domestic violence. Offer this support in a holistic way that is relevant to their culture.
17. Inform Aboriginal people (both on and off reserve) and other diverse communities about the domestic violence services available. Invest in community organizations so that they can develop programs and projects that deal with the prevention of domestic violence. Include funding to evaluate the programs and long-term funding to support programs that are successful.
18. Explore how a social marketing campaign could be useful in changing attitudes and behaviours, and especially in reaching diverse communities about issues of domestic violence. Any campaign should include the messages that:
  - a. Anyone can experience domestic violence.
  - b. Domestic violence, in all its forms, is unacceptable.
  - c. Sexual violence in intimate partner relationships is a crime.
  - d. Men have a responsibility in ending violence against women, including the promotion of positive male role models.
  - e. There are supports for victims to move forward from domestic violence.
19. Encourage adult education programs, schools, universities, and other institutions that offer education and training, to add training about domestic violence to their curricula.
20. Host conferences and workshops for practitioners in the field of domestic violence and develop a network to help them share new and innovative approaches and practices that look promising for addressing domestic violence.
21. Provide programs and follow-up services for abusers that address concerns other than their abusive behaviour, such as the impact of racism and needs such as education, housing, transportation, health, and literacy. Recognize that supporting the abuser to change behaviour assists in keeping victims safe.
22. Amend the Residential Tenancies Act to allow a tenant to end their lease without penalty if it is not safe for them to stay in their home because of the risks from domestic violence.<sup>375</sup>
23. Explore with First Nation communities and the federal and provincial governments the use of emergency protection orders on First Nation lands. This should include researching how First Nation communities across Canada are dealing with housing protocols and Band Council bylaws in relation to violence and abuse.
24. Establish collaborative relationships between police and First Nation service providers so appropriate approaches and protocols are established for dealing with Aboriginal people who experience domestic violence.
25. Support ongoing initiatives regarding Aboriginal models of restorative justice, First Nation tribunal and specialized court processes (e.g., *Gladue*) and perpetrator intervention.

### **Implementation of the Recommendations: NS Domestic Violence Action Plan**

The Nova Scotia government responded to this Prevention Committee Report by launching its Domestic Violence Action Plan in 2009.<sup>376</sup> The Plan was overseen by the Deputy Minister's

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<sup>375</sup> See Article 1974.1 of the Civil Code of Quebec [footnote in original].

<sup>376</sup> "Domestic Violence Action Plan" (Government of Nova Scotia, 2009).  
[https://novascotia.ca/just/publications/docs/Domestic\\_Violence\\_Action\\_Plan\\_EN.pdf](https://novascotia.ca/just/publications/docs/Domestic_Violence_Action_Plan_EN.pdf)

Committee on Family and Intimate Partner Violence. That committee included policy and program staff from numerous departments and was coordinated by the Department of Justice. The Plan stated that the Nova Scotia government “has been working on the issue of domestic violence for many years, but we have more to do.... We need a coordinated and sustained effort. This plan creates a coordinated and sustained effort to address one of society’s long-standing and pervasive problems.”<sup>377</sup> The Plan noted that only one in four Nova Scotian women who experience spousal violence reported it to police, and one in three reported it to a service-providing agency.<sup>378</sup>

The Action Plan set out the policies, programs, and services that were already in place and that were already dealing with issues/recommendations in the Prevention Committee report. It noted that some of these initiatives were started in 1995 based on the Framework and then the 2001 Russell Report. These initiatives including pro-arrest, pro-charge, and pro-prosecution directives; a province-wide intimate partner violence risk assessment by police; the high-risk case coordination protocol framework; domestic violence coordinator positions within police agencies; and ongoing intimate partner violence prevention training delivered to police and other frontline workers. The Action Plan also committed to a number of new initiatives, including:

1. Developing frameworks for evaluation by working with service providers and victims, perpetrators, and friends and family members; their experiences would be collected and analyzed as a “continuous feedback loop.”<sup>379</sup>
2. Co-facilitating regular networking sessions among government agencies and departments and community agencies focused on domestic violence prevention and intervention;
3. Creating a research and evaluation partnership with universities and other sources of expertise on domestic violence;
4. Formalizing a coordinated approach to training to ensure consistent material and efficient use of resources, consult with key stakeholders about training needs, and provide annual training targeting police, health professionals, frontline staff working with children, and community agencies;
5. Using existing committees and mechanisms in place to identify and respond to operational issues, including program and service evaluation, to build on the investments already made to address domestic violence;
6. Piloting a Neighbours, Friends, and Family campaign to educate the public about woman abuse and help them prevent it. This pilot would be run in three communities (urban, rural, and Aboriginal, with a culturally distinct campaign for Aboriginal communities) and be based on a similar Ontario program.
7. Developing a communications strategy and take other steps to ensure Nova Scotians know about and can access services and consistent resources on safety planning;
8. Amending the Police Act to allow police to share victim information with Victim Services;
9. Designing policy and guidelines to help health care providers identify, assess, and intervene appropriately in domestic violence cases;

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<sup>377</sup> “Domestic Violence Action Plan,” p. 1.

<sup>378</sup> “Domestic Violence Action Plan,” p. 2.

<sup>379</sup> “Domestic Violence Action Plan,” p. 7

10. Working with justice partner agencies and departments to make sure that appropriate policies and practices are in place to enforce the laws and meet provincial guidelines;
11. Conducting annual public opinion polls on attitudes about domestic violence;
12. Exploring options to provide second-stage housing for Indigenous women; and
13. Creating methods to evaluate the overall success of the Action Plan.

There do not appear to be any reports available online on the evaluation of the Domestic Violence Action Plan. The *Residential Tenancies Act* was subsequently amended to allow victims of domestic violence to leave a lease early without financial penalty.

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### 6.1.8. The 2014 HRM Roundtable Review (“Clairmont Review”) (Halifax Regional Municipality, 2014)<sup>380</sup>

The Halifax Regional Municipality commissioned a Mayor’s Roundtable to review its public safety programs in 2008.<sup>381</sup> That report, written by Professor Don Clairmont of Dalhousie University, did not address intimate partner violence. In 2014, the Halifax Regional Municipality asked Professor Clairmont to review the implementation of the 2008 report and identify any new areas and strategies that needed attention. For the 2014 report, Professor Clairmont reviewed data, policies, and programs, and conducted interviews with stakeholders.

Professor Clairmont noted positive trends in reported IPV in Halifax between 2008 and 2014, although he also noted that sexual assault reports in Halifax had increased and were well above the national average.<sup>382</sup> He stated, “One has to consider whether police and crown resources are adequate and whether the criminal justice system can do more to respond to sexual assaults... One area where the Justice system clearly can be improved is in providing more services to victims...”<sup>383</sup> He said that getting at the roots of sexual assaults would require changing the consumption of alcohol, which he described as a “key immediate cause” of sexual assault, and changing the deep support in the culture for sexual violence.<sup>384</sup> Professor Clairmont also described changes in the nature of sex work in Halifax toward what is seen as a safer indoor approach. He noted that there continued to be significant exploitation in sex work and that more data was needed.

Professor Clairmont commissioned a report by Verona Singer, Ph.D., on “Gendered Violence in the Halifax Regional Municipality”<sup>385</sup> and adopted her recommendations in his Report, along with a recommendation that the specialized domestic violence court in Sydney be adopted in Halifax. Dr. Singer’s report focused on intimate partner violence, sexual violence, and violence in sex work. She conducted interviews with service providers as well as a literature and data review.

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<sup>380</sup> “The 2014 HRM Roundtable Review,” Halifax Regional Municipality (2014). Volume I is available here: <https://dalspace.library.dal.ca/handle/10222/64613>. Volume II is available here: <https://ns.johnhoward.ca/images/HRMVolume2The2014RoundtableReview.pdf>

<sup>381</sup> “Violence and Public Safety in the Halifax Regional Municipality: A Report to the Mayor as a Result of the Roundtable,” Halifax Regional Municipality (April 2008), [https://dalspace.library.dal.ca/bitstream/handle/10222/64559/Violence\\_and\\_Public\\_Safety\\_in\\_HRM\\_Main\\_Report.pdf?sequence=1&isAllowed=y](https://dalspace.library.dal.ca/bitstream/handle/10222/64559/Violence_and_Public_Safety_in_HRM_Main_Report.pdf?sequence=1&isAllowed=y).

<sup>382</sup> “2014 HRM Roundtable Review,” Volume I, pp. 30–31.

<sup>383</sup> “2014 HRM Roundtable Review,” Volume I, p. 31.

<sup>384</sup> “2014 HRM Roundtable Review,” Volume I, p. 32.

<sup>385</sup> Contained in Volume II of “2014 HRM Roundtable Review,” available here: <https://ns.johnhoward.ca/images/HRMVolume2The2014RoundtableReview.pdf>

She noted that some women in Nova Scotia wanted officers to use more discretion when deciding to lay charges. For example, some women wanted more control over the response to their partner's violence; others wanted the violence to stop but did not want their partner charged. She also reported that service providers reported that cuts to social assistance rates and fewer affordable housing options were forcing more women to use transition houses for housing only rather than for safety reasons. The lack of mental health services also led to more women becoming transient and therefore returning to their abusers. She also reported that little to no funding had been attached to the Domestic Violence Action Plan (summarized above in section 6.1.7.) except for the pilot domestic violence court program in Cape Breton, and no staff members had been allocated to monitor the initiatives from the Action Plan or ensure they continued. Service providers also reported that prior to the amalgamation of the City of Halifax, the City had spearheaded initiatives such as community safety audit tools for women in the early 1990s. Since amalgamation, the municipality did not appear to have invested in intimate partner violence support except through its existing policing and victim services.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission<sup>386</sup>**

1. Improved cooperation, information-sharing, and knowledge exchange between and among government and non-profit agencies and organizations across the region, and more coordination and liaison between the municipality, the province, and the federal government. Options include creating a social development planning capacity in the Halifax Regional Municipality that would look at gendered violence from a holistic approach, where the public safety unit would not be attached to the police department, and gendered violence would be part of a broader social planning concept, beyond the narrow confines of a legal framework.
2. Increase access to safe and affordable housing for women experiencing violence.
3. Develop a funding strategy for service providers, including shelters, second-stage housing, counselling services and supports, men's programs, along with greater resources for police and their victim services. Review all programs and policies implemented in the municipality for how they will affect the safety and well-being of women.
4. Train service providers, including initial training for organizations and agencies on how to conceptualize and respond to intimate partner violence, and provide police officers with refresher and updated courses on intimate partner violence, intimate partner violence in immigrant communities.
5. Create a domestic violence unit or specialized domestic violence police officer within the police force.
6. Ensure staff are solely dedicated to the provincial Domestic Violence Action Plan to ensure recommendations are implemented, evaluated, and reported on.

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<sup>386</sup> These recommendations have been condensed and reworded for clarity.

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**6.1.9. Independent Review of the Police and Prosecution Response to the Rehtaeh Parsons Case (2015)**<sup>387</sup>

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Rehtaeh Parsons was a high school student in Dartmouth. In 2011, she was sexually assaulted by several teenage boys while others watched and took photographs. Students harassed Ms. Parsons after a photograph of the assault was disseminated, causing significant distress to Ms. Parsons. The police investigation of the assault and photograph dissemination took a year, and police did not lay charges or take steps to prevent the further dissemination of the photograph or bullying of Ms. Parsons. Ms. Parsons changed schools several times to try to escape the harassment. In April 2013, Ms. Parsons died by suicide at the age of seventeen. Following her death, the RCMP reviewed the case and laid child pornography charges against two of the youth in light of new evidence. No charges were laid regarding the assault.

The government of Nova Scotia asked Murray Segal to review the police investigation, the decision not to lay charges for the assault and the dissemination of the photograph, and the role played by Victim Services. The police investigation had been conducted by the Halifax Regional Police (HRP), which is an integrated service that includes the RCMP (in certain geographical locations) and the Halifax municipal police (in the centre of Halifax). Ms. Parsons first met with members of the RCMP in Cole Harbour, where she lived. This interview was not recorded, and there was no representative from the Department of Community Services, as required in interviews with children. The RCMP then forwarded the electronic file to the Sexual Assault Integrated Team (SAIT); this should have been done immediately, but there was a delay of a day. When the file arrived at SAIT, only one of two of the NCO positions in that office was filled at the time, so it was not immediately assigned. After several months of investigation, the Crown advised police that it would not proceed with sexual assault or child pornography charges, based on their assessment of whether there was a realistic prospect of conviction. Police therefore did not lay charges. Segal found that the Crown's opinion relating to the child pornography charge was legally incorrect.

The Report noted that police officers in Nova Scotia were offered a new course on trauma-informed responses to sexualized violence as a result of Ms. Parsons's case. Segal noted that although considerable training is now available to members of the SAIT, members are not required to take that training upon their assignment to the unit. This is contrary to the RCMP Operational Manual, which requires that divisions ensure that members receive "adequate training in sexual assault investigations and have continual access to resource and training material."<sup>388</sup> The Review also identified problems arising from the decision to have the incident investigated by the sexual assault team rather than by the child pornography team or a joint team, given the overlap in the two offences. Communication between the police and the family was also an issue, although Segal noted that officers are required to protect information they gather during an investigation. He therefore recommended that Victims Services act as a conduit between the police and victims both after charges are laid and during the investigation. (At the time of the Parsons investigation, Victims Services only provided pre-charge services in domestic violence cases; however, it did become involved in the Parsons case for a short period of time.) He also recommended that investigations involving child abuse should generally be prioritized over adult

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<sup>387</sup> "Independent Review of the Police and Prosecution Response to the Rehtaeh Parsons Case," submitted to the Minister of Justice and Attorney General of Nova Scotia (October 2015), <https://novascotia.ca/segalreport/Parsons-Independent-Review.pdf>.

<sup>388</sup> "Independent Review of the Rehtaeh Parsons Case," p. 47.

sexual assaults, given children's particular vulnerabilities and the challenges of prosecuting when young people's recollections are involved.

Segal also identified workload, short-staffing, and the practice of drawing SAIT investigators into homicide investigations or other special projects that needed resources as issues affecting the investigation. He did not find any obvious reliance on myths and stereotypes about sexual assault complainants in the investigation or in the Crown's assessment of the case. However, he noted that underreporting, undercharging, and low conviction rates appear to be particularly prevalent in Nova Scotia compared with other provinces.<sup>389</sup> He identified this as a problem warranting attention.

The Report also noted the limitations of traditional police investigations and criminal prosecutions as tools for reducing cyberbullying, noting that cyberbullying requires additional solutions outside that framework, even where those solutions may on occasion interfere with prosecutions. He noted that Nova Scotia had developed several such initiatives in the wake of Ms. Parson's death, including the Cyber-SCAN initiative developed by the Department of Justice under the Safer Communities and Neighbourhoods Act. The unit is composed of non-police investigators employed by the province to investigate allegations of cyberbullying and intervene if warranted. Segal also noted new legislation, the Cyber-safety Act, which created the tort of cyberbullying and permitted protection orders to stop cyberbullying.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 2) An integrated "sex crimes unit" should be created, or there should be closer collaboration between SAIT and ICE on investigative files that touch on both their areas of expertise. Joint task forces should be created when appropriate. ICE and SAIT should be located in closer physical proximity to facilitate exchanges of information and advice, and investigators should be encouraged to work collaboratively and share information.
2. (Recommendation 3) More efforts should be made to make both the general public and key institutions, such as the police and schools, aware of novel ways to address cyberbullying. The police, along with other authorities and stakeholders such as the Department of Education and the Department of Justice representatives from the CyberSCAN Unit, should develop a "cyberbullying" protocol that would identify in which instances to use these new alternatives. The protocol should be designed with a view to flexibility and acknowledge that various approaches can be used simultaneously. Given the kind of damage that cyberbullying can rapidly cause, the protocol should state that if police investigators have the requisite grounds to prevent further instances of cyberbullying or to seize images or electronic devices used to commit cyberbullying-type offences, they should consider obtaining a recognizance order or seizing the images or devices in a timely way. They should at all times consider interim remedies to promptly put an end to the cyberbullying. [...]
3. (Recommendation 4) Upon being assigned to SAIT or as soon thereafter as practicable, investigators should receive training specific to sexual assault investigations and to victim responses to sexual violence. Consideration should be given to creating a buddy system or assigning a mentor to officers who are new to SAIT. Investigators should also develop a tentative overall investigative plan to be discussed with and reviewed by a superior at the outset of the investigation. This value-added step should be integrated into the current quality assurance system to make it less pro forma. Crown prosecutors who handle sexual assault

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<sup>389</sup> "Independent Review of the Rehtaeh Parsons Case," p. 83, fn. 100.

cases should also receive more training about sexual violence and responses to sexual violence, with a particular focus on trauma-informed responses. [...]

4. (Recommendation 5) Police services should assess whether police-based victim services can be expanded to cover sexual assault investigations and other crimes involving serious violence. Police officers who may come into contact with victims of sexual violence should be made aware of the availability of victim services to facilitate communications with complainants and their families and be encouraged to make appropriate referrals to and use of these services.
5. (Recommendation 6) Police should prioritize investigations involving young persons—both as potential targets and/or complainants or victims—over cases involving adults. Investigations involving persons in crisis should also be prioritized over cases that do not have a similar urgent component.
6. (Recommendation 7) SAIT should be sufficiently resourced so that investigators can complete their investigations in a timely manner. SAIT should be a last resort for additional human resources that may be required to assist with other matters such as homicide investigations.
7. (Recommendation 8a) The PPS Directive on Providing Advice to Police should be amended to require that, in cases where the Crown prosecutor opines that there are insufficient grounds to lay a charge or that there is no realistic prospect of conviction—and unless the prosecutor has himself or herself undertaken a thorough review of the file, the factual assumptions that underlie the opinion should be set out for the police investigator.
8. (Recommendation 8b) The PPS Directive on the Decision to Prosecute should clarify that the “realistic prospect of conviction” threshold involves a determination that a conviction is “more than technically or theoretically available” and, in the event of uncertainty on that point, the Crown prosecutor should consult with supervisors and experienced colleagues.

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#### **6.1.10. Independent Officer Review: Susan Olive Butlin & Ernie “Junior” Duggan, Complaints (RCMP, December 2019)<sup>390</sup>**

Susan Butlin was a resident of Bayswater, Nova Scotia and the mother of two adult children.<sup>391</sup> Ms. Butlin complained to her local RCMP detachment in Colchester County about the conduct of her neighbour, Ernie “Junior” Duggan, including sexual assault and suspected vandalism. The RCMP officers who investigated her initial complaint did not lay charges. They recommended that Ms. Butlin apply for a peace bond against Mr. Duggan. After Mr. Duggan was served with the peace bond summons, his wife called 911 to report that she feared Mr. Duggan would kill Ms. Butlin or himself and that she believed he may have a gun. Police arrested Mr. Duggan for impaired driving but did not lay other charges. The judge hearing the peace bond requested that the RCMP investigate the matter, as Ms. Duggan’s application suggested that a sexual assault had occurred. The RCMP reviewed the file but confirmed its decision not to lay charges. On

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<sup>390</sup> “IOR: Butlin – Duggan complaints.” This document is available in Relativity, at COMM0048906.

<sup>391</sup> In the investigation materials attached to the Independent Officer Review, Ms. Butlin is sometimes referred to as “Susan” or “Susie McNutt.” She is referred to throughout the Review itself as “Susan Butlin.” The information regarding the events preceding Ms. Butlin’s death is set out in the Agreed Statement of Facts filed in support of Mr. Duggan’s guilty plea: <https://www.halifaxexaminer.ca/wp-content/uploads/2020/06/1-1.pdf>.

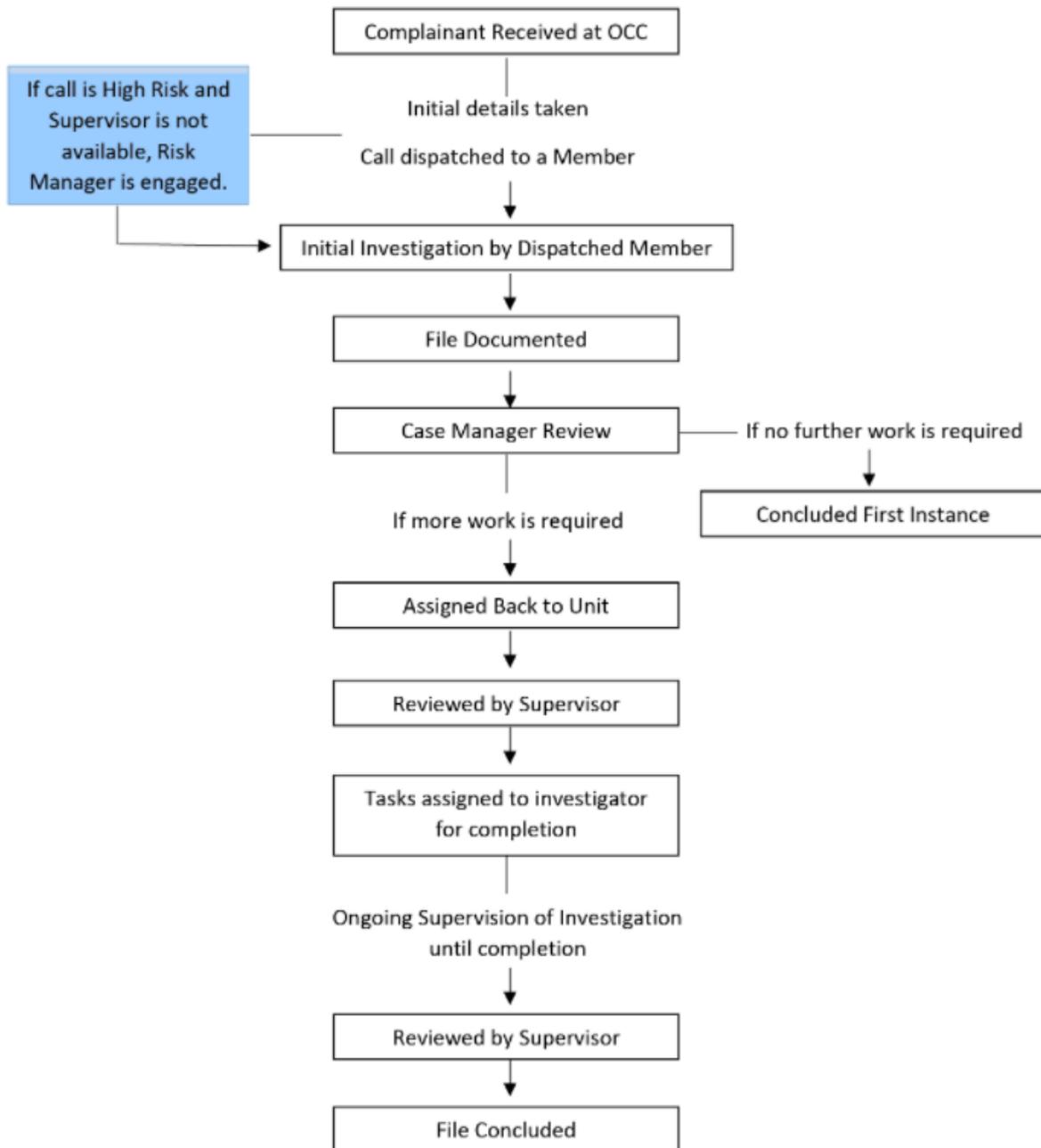
September 16, 2017, Mr. Duggan murdered Ms. Butlin. Police then pursued Mr. Duggan, who engaged in a standoff with police for several hours before he was arrested.<sup>392</sup>

After Mr. Duggan was convicted of Ms. Butlin's murder, the RCMP arranged for a review of its officers' interactions with Ms. Butlin and Mr. Duggan. Three senior officers with the Halifax Regional Police/RCMP Integrated Criminal Investigation Division conducted the review.

The Colchester County RCMP District has three local detachments, in Tatamagouche, Stewiacke, and Bible Hill. There are 28 constables and five corporals in the district; one sergeant, who is the Operations NCO; and one staff sergeant, who is the District Commander. The Review set out the responsibilities and process for investigating calls in the following flow chart. The OCC is the Operational Communications Centre, which receives and dispatches calls from the public; the Case Manager is an NCO (non-commissioned officer) who reviews the initial documentation on the file and sends it back for further investigation if necessary; the Supervisor is the officer with direct supervisory responsibilities for the investigating officer; and the Risk Manager is a senior NCO who works in the OCC and provides guidance in the initial response to critical or high risk calls where a supervisor or Operations NCO is not available.

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<sup>392</sup> This information is set out in the Agreed Statement of Facts filed in support of Mr. Duggan's guilty plea. <https://www.halifaxexaminer.ca/wp-content/uploads/2020/06/1-1.pdf>

**Investigative Process Flow Chart**

On August 7, 2017 at 2:23pm, Susan Butlin called 911 and spoke with a call taker at the Operational Communications Centre, then based in Truro, Nova Scotia. The call was recorded, and later transcribed. During the call, Ms. Butlin stated that she wished to make a complaint about a sexual assault that had occurred in July. She named her neighbour as the perpetrator, provided some details about the incident, and requested that a female member be dispatched. The call

taker stated that no women were scheduled to be on shift at that time, and suggested that Ms. Butlin speak with a male member who would call her, reassuring her that “they’re pretty empathetic”.

An RCMP member from the Bible Hill detachment spoke with Ms. Butlin by phone that day. At the end of that conversation, the RCMP member “informed Butlin that based on what she stated there was no criminal offence and referred her to the Peace Bond process. Butlin responded that this was the reason she had requested a female member.” The RCMP member who originally responded therefore arranged to have a female member follow up with her.

At 6:37pm on August 7, 2017, Ms. Butlin spoke with a female RCMP constable from Bible Hill detachment, in Ms. Butlin’s home near Tatamagouche, Nova Scotia. This conversation was recorded, and later transcribed. Ms. Butlin advised the RCMP member that she was “quite shocked” and “totally floored” when her neighbour, Mr. Ernie Duggan, crudely initiated sexual activity after inviting himself to her home for a drink. She clearly stated that she was not open to that activity and walked away from him. When Mr. Duggan did not leave or desist, she became “friggin scared” and engaged in some sexual activity “to keep things calm ... you don’t know ... what in the hell this neighbors gonna do to ya”. Ms Butlin reiterated in response to follow up questions that when the sexual touching occurred she told Mr. Duggan clearly that she was not interested in sexual activity, that when he did not listen or desist, she became “really, really scared” and “trying to keep him calm, to think, okay, is he gonna jump me or what.” Afterwards, she “just kept saying no”. On further follow up, she explained “I was scared, because he’s a very strong man ... and he was really, really drunk, and when you put those two things together, you don’t know what they’re gonna do.”

Ms. Butlin moved to another area of her home. Mr. Duggan followed and made further vulgar remarks, in response to which Ms. Butlin insisted that she was not interested in sexual activity and he should go home to his wife.

The transcript records that Ms. Butlin told the RCMP member that as Mr. Duggan left, he said “well, I may be back ...” and that she took this as a threat.

After receiving this statement, the RCMP constable confirmed that “based on the information at hand there was no criminal offence, and that she could pursue via Peace Bond if she wished.” A note within the Independent Officer Review states that “the member and supervisors after review came to the conclusion that the sexual contact did not appear to be forced and was consensual.”<sup>393</sup>

No charges were brought against Mr. Duggan and there is no record of the RCMP having sought a statement from Mr. Duggan about these allegations.

On August 10, 2017, Ms. Butlin filed her own information for a Peace Bond. In the grounds for seeking a Peace Bond, she reiterated many of the details she had provided to the RCMP. Mr. Duggan was served with a summons for the Peace Bond on August 16, 2017.

On August 21, 2017 Mr. Duggan’s wife, April Duggan, called 911 “in distress” to report that she thought her husband was going to kill Ms. Butlin. Mrs. Duggan reported having fled her family home after Mr. Duggan had kicked in a locked door. She expressed fears for her own safety and

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<sup>393</sup> Ibid at 37.

that of Ms. Butlin, and also that Mr. Duggan may harm himself. Mrs. Duggan subsequently called 911 again to report that Mr. Duggan may have obtained a gun.

Two RCMP constables attended the Duggan residence. Due to the lengthy response time anticipated, 911 dispatch called Ms. Butlin and, after confirming that there was no immediate disturbance at her residence, advised her to “hold tight there and just ... I’m not trying to scare you or anything there, but if you just want to lock your doors and stuff, just, just until officers come out” to deal with Mr. Duggan.

Meanwhile, the responding RCMP members “became aware that DUGGAN may be operating his truck while impaired”. They investigated and confirmed that this was the case, and arrested and charged Mr. Duggan for impaired operation of a motor vehicle.

On August 26, 2017 Ms. Butlin reported that she had been receiving text messages from Mr. Duggan “trying to intimidate her from going through with the Peace Bond process.” She stated that she had called Bible Hill RCMP detachment on August 25, 2017 and left a message for the female RCMP constable who had taken her statement, but that no one had returned her call. An RCMP constable reviewed the text messages that Ms. Butlin had received and “determined there was no basis for charges”. The internal review report notes that the responding member ascertained that Ms. Butlin “had not directly advised DUGGAN to stop contacting her.”

On August 29, 2017, the RCMP received an email from a Crown attorney. The email was sent at the request of the judge who had heard the application for a Peace Bond. This judge suggested that the police look into the matter “as it was likely more than a Peace Bond.” An RCMP Sergeant reviewed the file and subsequent harassment complaint and “supported the decision not to pursue charges.” He assigned two constables to review the file.

On August 30, 2017, one of these constables conducted a further review and “concurred with previous investigators that there were no grounds for charge”. He documented his reasons for this conclusion, including that “Butlin’s statement provides no evidence of sexual assault, rather consensual touching.” On this day, Ms. Butlin’s application for a Peace Bond was heard. It was adjourned to September 13 and subsequently to October 3, 2017.

On September 13, 2017, an RCMP corporal documented that Ms. Butlin “had contacted him regarding not being satisfied with police response to her sexual assault complaint. He reviewed her file in full and agreed no charges were warranted.” This corporal met with Ms. Butlin on September 14, 2017 to explain his review and decision not to charge.

On September 17, 2017, Mr. Duggan murdered Ms Butlin with a shotgun. At the time of the RCMP review of these matters, Mr. Duggan had been charged but the case had not been tried. In June 2019, Mr. Duggan pleaded guilty to the second-degree murder of Ms. Butlin.<sup>394</sup> Ms. Butlin was 58 years of age at the time of her death.

The Independent Officer Review made the following findings:

1. The initial investigation of Ms. Butlin’s complaint on August 7, 2017 was incomplete. The initial statement from Ms. Butlin was taken over the phone, which was not a trauma-informed

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<sup>394</sup> CBC News, “Tatamagouche-area man pleads guilty to murdering neighbour” 21 June 2019 online: <https://www.cbc.ca/news/canada/nova-scotia/ernest-duggan-susie-butlin-tatamagouche-murder-guilty-plea-1.5185162>.

approach to a sexual assault investigation. It was only because Ms. Butlin mentioned during this phone call that she had hoped to speak to a female officer that an officer interviewed her in person. Police did not speak to any of the people who might have had information about the assault, such as Mr. Duggan's wife, her boyfriend, sister, therapist, children, or the friends whom she said were present when Mr. Duggan contacted her after the incident. Police also failed to obtain any of the texts or Facebook messages Ms. Butlin had mentioned. They also failed to pursue the possible threats made toward her through her son.

2. They did not conduct a background history check on Mr. Duggan and did not enter this incident into the Violent Crime Linkage Analysis System (ViCLAS).
3. They did not speak to Mr. Duggan.
4. Even though Ms. Butlin said she was fearful of Mr. Duggan, the officers did not discuss safety planning or the Protection of Privacy Act<sup>395</sup> with her. There is no record of any referral to victims services. The referral to the Peace Bond process appeared to have been verbal only, despite the fact that the Public Prosecution Service had created a brochure, available in hard copy and online, which outlines the process for obtaining a peace bond.
5. The officers documented the information about the swimming pool in the sexual assault complaint file but did not open a separate occurrence for it and did not investigate it.
6. The officers did not appear to consider consulting with a Crown or subject-matter expert.
7. It does not appear that officers informed Ms. Butlin of their decision regarding whether to charge until she requested it.
8. During the interview of Ms. Butlin at her home, which was recorded, the investigating officer did not pursue issues in detail, such as what exactly happened in the bathroom, Mr. Duggan's level of intoxication, his stature, the size of the bathroom, whether he was blocking the door, or the difference in their ages and physical fitness. Ms. Butlin also mentioned that Mr. Duggan started to touch her breast, but the officer did not explore this further. The officer also failed to fully explore the complaint of harassment.
9. Ms. Duggan referred to her sons being contacted by a friend of Mr. Duggan, who Ms. Butlin said was involved in criminal activity. This was not followed up in questioning or documented in the file.

The Review noted that although taking these additional steps might not have changed the ultimate decision regarding charges, "it is important to understand the gravity of the allegation and the obligation to both the complainant and the accused for the police to take all reasonable steps to gather as much information as possible to form an informed decision."<sup>396</sup>

The Review also identified several instances of apparent bias by both members and supervisors. These include:

1. Supervisor comments on the file stating that the sexual contact was consensual, despite Ms. Butlin having clearly stated that she was saying "no" to Duggan, that he touched her, that she feared she would be raped, that he was "big and drunk," that she felt isolated, and that she was concerned about what Mr. Duggan would be capable of if she did not cooperate.
2. It appeared that officers believed that the fact that Ms. Butlin returned to the bathroom to see what Mr. Duggan was doing constituted an invitation to the sexual contact. She was never

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<sup>395</sup> This legislation addresses trespassing and other property offences.

<sup>396</sup> "IOR: Butlin – Duggan complaints", p. 16.

given the opportunity to explain her reasons for returning to the bathroom in more detail, and the fact that her grandchildren were in the home appeared to have been lost in the review of the file.<sup>397</sup>

3. There were references in the file to the fact that Ms. Butlin described Mr. Duggan as drunk even though she had said she only gave Mr. Duggan one glass of wine. The officers do not appear to have considered the possibility that Mr. Duggan consumed alcohol before coming to her house.<sup>398</sup>

The Independent Officer Review also considered the officers' response to the August 21, 2017 call from April Duggan, which led to the impaired driving charge against Mr. Duggan. The review noted that Ms. Duggan had said that she believed her husband "was going to kill the neighbour," that he had been deteriorating over the past several days since learning of Ms. Butlin's allegations, that she feared for her own and Ms. Butlin's safety, that her husband had been violent that evening, kicking in a locked door, and that she believed he may have gone to get a gun. Given this very concerning information, which clearly demonstrated a significant safety risk to Ms. Butlin, there were significant deficiencies in the investigation,<sup>399</sup> including:

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<sup>397</sup> The written Supervisor Review, dated August 30, 2017, stated:

[Ms. Butlin] admits she was not forced to do anything with Duggan. She made no attempt to call for help or even report the incident to police until her pool was damaged. She knew he was in the bathroom with his pants down and she went back to the bathroom a second time without his prompting, which is when she engaged in sexual activity with him... Butlin's statement provides no evidence of sexual assault, rather consensual touching. Duggan would need to have touched her for a sexual purpose, or in a manner which violated the sexual integrity of the person... Duggan did not display any violent or domineering behaviour, and Butlin did not provide any evidence to support a reason for fearing Duggan other than he was "big and drunk" (drunk from one glass of wine that she provided).

In Ms. Butlin's recorded statement to the female officer, she states several times that if her grandchildren had not been there, she would have kicked Mr. Duggan or fought with him, and she said she did not want to traumatize them. She also said, "Your other officer said, well because you touched his penis and you sucked it, because I was friggin scared, and what else would you do, like, when your [sic] trying to keep things calm, I did only what, trying to keep him, tame, or whatever you wanna call it, because I can't explain, unless your [sic] in a situation, that you don't know if your [sic] gonna get raped er, what in the hell this neighbors [sic] gonna do to ya..." (p. 85). She also said she went back into the bathroom because he wasn't coming out, and she wanted to get him out. She then said "I was scared, obviously I was scared, and I did touch it... I was really scared, and I just kept saying no..." (p. 88). Although the Independent Officer Review noted the significant distance between the detachment and Ms. Butlin's home, there was no reference to the likely response time as a possible factor in Ms. Butlin's decision not to contact police at that time. Ms. Butlin also told the female officer that she did not call the RCMP immediately after the incident out of concern for the impact on Mr. Duggan's wife if she did so.

<sup>398</sup> The file materials appended to the Independent Officer Review show that in Ms. Butlin's original call to the police, she stated that she and Mr. Duggan and others were having a bonfire down at the beach before he came into her home. In her recorded statement, she said that her grandson was at the neighbouring property, and they were starting to have a bonfire with some friends, that she went over to get her grandson, that one of the people there offered her a beer, and that Mr. Duggan was there. At that point he agreed to bring her grandson back to her home on his tractor. He then asked to come into her home and have a drink.

<sup>399</sup> The investigation reports appended to the Review show that the officers who responded to April Duggan's call spoke to Mr. Duggan outside his home while he drank a beer. He was cooperative and understanding and said he respected policing. He said he and April had been going through a rough patch and she had locked him out, so he kicked the door in. He said he would never hurt, threaten, or assault his wife and would never hurt anyone. He said he was not suicidal. He was intoxicated and continued to drink beer during this conversation. Ms. Duggan, who had fled to a friend's house, told the police that Mr. Duggan had been paying off his mortgage and bills and saying he wanted her financially sound before he left. She believed he was suicidal. Officers then found Mr. Duggan driving his truck and arrested him, placing him in custody overnight. They told April Duggan that he was in custody. There is no record of any further discussion with her regarding safety planning or her fears of Mr. Duggan. There is also no indication that the officers considered investigating this matter as an intimate partner violence incident, despite Ms.

- The officers did not obtain a statement from April Duggan or another person (name redacted) who may have relevant information.
- They took no steps to determine if Mr. Duggan had obtained or had access to a gun.
- They did not document their contact and conversation with Mr. Duggan.
- There was no indication that a Risk Manager or supervisor was involved in this call.

Next, the Review examined the report by Ms. Butlin on August 26 that Mr. Butlin was sending messages to her and trying to intimidate her into giving up on the peace bond process. The investigating officer documented that he spoke to Ms. Butlin, and the messages were not of a criminal nature. In the messages, Mr. Duggan said he would tell people about Ms. Butlin on Facebook. The Review concluded, “Given the ongoing events since the initial sexual assault complaint, these allegations should have been taken seriously and a thorough investigation conducted.” Such an investigation would have included taking a formal statement from Ms. Butlin, obtaining copies of the text messages, obtaining a statement from April Duggan, and speaking to Mr. Duggan. Because these steps were not taken, it is impossible to know whether there were grounds for charges of harassment or intimidation of a justice participant.<sup>400</sup> The Review noted that there were differences between what Ms. Butlin said in the recorded initial call and what the investigating officer documented. Because the officer did not take a recorded statement from Ms. Butlin, it is unclear whether the officer misunderstood what Ms. Butlin was saying or whether Ms. Butlin said something different to him from what she said when she called in her initial complaint. A recorded statement would have eliminated these questions. The Review also noted that at the very least, the information regarding Mr. Duggan’s contact with Ms. Butlin should have been forwarded to the Crown to assist her in preparing for the first appearance on the peace bond application, which took place four days later.<sup>401</sup>

The Review also noted problems with documentation by both investigating members and supervisors in all of the files, in officers’ notes and in written reports. Without this documentation it is impossible to know if the investigating officers acted properly or made decisions appropriately given the information known to them at the time. The Review made a particular note that other than the reviews that occurred at the request of Judge Bégin and the Crown Attorney, “there is virtually no documentation on any files indicating that the files were ever reviewed by a Case Manager or Supervisor.”<sup>402</sup> Despite the fact that supervisors were involved at various times, they did not identify or address the problems with the investigation. The two separate supervisors who reviewed the sexual assault and harassment files on August 29 and 30 did not identify any issues for follow up, and both agreed that no charges were warranted. Neither of them included the Impaired Operation file in their reviews, which contained important information on the threats against Ms. Butlin. They may not have realized it contained relevant information because it was coded as an Impaired Operation file. A third supervisor, who reviewed the sexual assault investigation at Ms. Butlin’s request on September 13, 2017, also reviewed the peace bond

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Duggan’s report that he had broken down a door in the course of an argument between the two. The Review does not make reference to these omissions.

<sup>400</sup> The investigative records appended to the Review suggest that the investigators considered only whether the messages were “threats of a criminal nature” rather than whether the communications could amount to the offence of intimidation of a justice system participant or other offence. In her initial call to the OCC to report the messages, Ms. Butlin said that Mr. Duggan was texting her with allegations of improper sexual conduct on her part and said that he would go to authorities to prevent her from having exchange students in her home.

<sup>401</sup> The court record shows that at the first appearance of the peace bond application on August 30, 2017, Judge Bégin directed Mr. Duggan to have “no contact whatsoever” with Ms. Butlin.

<sup>402</sup> “IOR: Butlin – Duggan complaints”, p. 20.

application. However, that supervisor also failed to direct members to take any additional steps. The Review stated:

It is vital that supervisors are fully engaged in reviewing files, including identifying deficiencies and outstanding tasks that need to be taken. This is especially vital in serious allegations such as a sexual assault. In instances where supervisors do not have training or dedicated experience in a specific area it is key that they identify outside parties who do possess the required background so that consultation can be undertaken if needed.<sup>403</sup>

Finally, the Review identified problems with training. None of the members involved in the investigations appeared to have had any advanced investigative training, particularly regarding sexual assault investigations. None had had training in trauma-informed approaches. Because the Case Manager and Risk Managers are only available at the initial stages of an investigation, the day-to-day supervision of investigations is left to the unit or team supervisors. However, none of the training required for supervisors include training on advanced investigations.

The RCMP National Headquarters Sexual Assault Review Team (SART) had prepared a Best Practice Guide for Sexual Assault Investigations, which included a checklist. The Review described it as an effective tool for members and supervisors to ensure that steps in the investigation are not missed. There was nothing in the files suggesting that any of the investigators or supervisors used this guide during their investigations or reviews of Ms. Butlin's sexual assault complaint.

As noted, the Review concluded the investigators had not contacted a subject matter expert. The Review noted that consultations with such experts, such as officers with specific training or experience, or with Crown counsel "provide an opportunity for an impartial review of the information at hand and can assist investigators in making a determination of what, if any, outstanding tasks need to be completed."<sup>404</sup> It noted that this kind of consultation is routinely done in homicide investigations.

There was no indication of any personal relationships between any of the investigators and Ms. Butlin or Mr. Duggan. The reviewers concluded that the gaps in the investigations appear to be related to performance rather than intentional acts or omissions, and the initial conclusion that the sexual contact between Mr. Duggan and Ms. Butlin was consensual appeared to have affected the police perception of their subsequent interactions. The Review noted the increasing scrutiny of police investigations of sexual assault and the fact that SART reviews from across the country

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<sup>403</sup> "IOR: Butlin – Duggan complaints", p. 21.

<sup>404</sup> "IOR: Butlin – Duggan complaints", p. 23. A timeline of events, which was appended to the Independent Officer Review, states that the Crown, Ms. Brown, agreed with the officers that there were no reasonable and probable grounds to support a charge. However, nothing in the file materials suggests that Ms. Brown gave any opinion or was asked to give her opinion about whether the evidence supported a charge. The correspondence between the reviewing officer and the Crown on August 30, 2017 shows that the officer sent a brief email stating that he and another officer had reviewed the file and that based on that review and the comments of the supervisor, "we would support the decision made not to proceed with charges in relation to the sexual assault allegations. We have also noted there are inconsistencies in the information written on the Peace Bond application compared to the information she provided previously." The officer did not provide any other explanation of the conclusion that there were no grounds for a charge and did not provide Ms. Brown with any information about the contents of Ms. Butlin's statements to police. Ms. Brown expressed reluctance to tell the court about inconsistencies in Ms. Butlin's statements and said she would simply advise the court that the investigator does not have reasonable and probable grounds to believe an offence has been committed (pp. 67–68). There were no records of any further communication with the Crown about the decision not to charge.

had identified problems with investigators' understanding of consent and other issues in sexual assault cases. This had led to many "unfounded" complaints being reopened for investigation.

The Review concluded that this case "clearly demonstrates the need and priority required for specialized training for all investigators and supervisors tasked with these often-complex investigations"<sup>405</sup> and for continued oversight of sexual assault investigations by SART and Division Management, as was being planned at the time of the Review. The gaps in knowledge, skills, and abilities of investigators in sexual assault cases were not unique to the Tatamagouche Detachment. The reviewers recommended that until all members receive advanced training in sexual violence investigation, the members of the Halifax Integrated Sexual Assault Investigation Team (SAIT), who are highly trained subject-matter experts, be made available to consult with frontline investigators across "H" Division.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission<sup>406</sup>**

1. Increase availability of advanced investigative training for frontline members. While it is not likely feasible for all general duty members to receive advanced or sexual based investigative training, steps can be taken to ensure more members are trained. It is important for all detachments to have persons well versed in advanced investigations. These members can then be utilized for investigations such as this, where further investigation is beneficial in working to gather all available evidence prior to making a determination on an allegation. This could be done through an online training course in order to train large numbers in a short period time.
2. Investigative training for supervisors. Similar to the recommendation that all frontline members have more access to advanced investigative training, all members performing investigative supervisory roles should have a training component that deals with advanced investigations. A portion of this training should focus specifically on sexual offences. Again, this could be delivered online.
3. Referral to/use of the Best Practice Guide including Advanced Checklist. In areas where members (both frontline and supervisors) do not have training and experience, the Best Practice Guide for Sexual Assault Investigations prepared by the National Headquarters Sexual Assault Review Team (SART) should be reviewed and consulted and the checklist completed.
4. Identify and Utilize Supports (SMEs). In situations where there is uncertainty, it is reasonable for members to seek out Subject Matter Experts (SME) to review the information collected and identify potential outstanding issues. This could fall to members who have received specific training, members who have extensive experience in a specific area of investigation or by direct consultation with Crown Counsel.

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<sup>405</sup> "IOR: Butlin – Duggan complaints", p. 24.

<sup>406</sup> The text of these recommendations has been condensed and slightly paraphrased.

## 6.2. Federal

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### 6.2.1. The War Against Women: Sub-Committee on the Status of Women (House of Commons, 1991)<sup>407</sup>

The Standing Committee on Health and Welfare, Social Affairs, Seniors and on the Status of Women established the Sub-Committee on the Status of Women in December 1990. Its mandate was to inquire into the definitions, incidence, causes, and costs of violence against women, as well as the response of the criminal justice system, community groups, and government, and the role and responsibility of governments to seek solutions to the problem of violence against women. The Sub-Committee heard from abused women, government officials, service providers and community-based agencies, advocates for victims of violence against women, and experts and commentators.

The Report, issued in 1991, opened with reference to the murder of fourteen women engineering students at École Polytechnique two years earlier: “The Montreal massacre was the catalyst for Canadians to demand that violence against women be put on the public agenda.” It accepted the definition of violence against women provided by the Canadian Advisory Council on the Status of Women, as “a multifaceted problem which encompasses physical, psychological, and economic violations of women which is integrally linked to the social/economic/political structures, values, and policies that silence women in our society, support gender-based discrimination, and maintain women’s inequality.”<sup>408</sup>

#### Recommendations Relevant to the Mandate of the Mass Casualty Commission

1. The Committee recommends that the federal government exercise its leadership role to ensure security of the person for all Canadian women by mounting a national multimedia education campaign on violence against women. The campaign should expressly denounce violence against women as criminal behaviour and emphasize societal responsibility for its prevention.
2. The Committee recommends that the federal government initiate discussions with provincial and territorial governments to ensure that the community has adequate resources to accommodate the demand for services that will emanate from the multimedia campaign on violence against women.
3. The Committee recommends that the federal government take the lead role on gender sensitivity training for law enforcement personnel by requiring police officers in the federal sector (RCMP) to take mandatory training and refresher courses that focus on the prevalence of violence against women and children, its symptoms, its consequences for victims, and appropriate ways to respond to victims’ needs. The content of the courses should be developed in consultation with frontline agencies that work with female victims of violence. The federal government should make available appropriate resources to provincial and municipal governments to enable them to require their personnel in the law enforcement, social and health sectors to take these courses.

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<sup>407</sup> “The War Against Women: Report of the Sub-Committee on the Status of Women,” House of Commons Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women (June 1991).

<sup>408</sup> “The War Against Women,” p. 3.

4. The Committee recommends that the federal government take the lead role to ensure that secure long-term funding is available for frontline agencies providing services to assaulted and abused women and girls. Financial support is needed to ensure that services will be accessible to all women in need and sensitive to the needs of women with disabilities, elderly women, and women who are immigrants and or members of visible minorities.
5. The Committee recommends that the federal government take the lead role in coordinating the development of a housing policy in Canada and providing tangible support to resolve the crisis in affordable and accessible accommodation confronting low-income earners and the poor, particularly for women who are not safe in their homes.
6. The Committee recommends that the federal government take the lead role in stressing the importance of the mandatory charging policy in cases of physical and sexual assault and abuse by directing the RCMP to assiduously follow the policy. The federal government should also encourage provincial governments to direct their police forces to consistently support their respective mandatory charging policies.
7. The Committee recommends that an administrative body or task force, comprised of individuals with expertise in law as well as other expertise in areas affecting women's equality, be struck and charged with the task of developing equality-enhancing legislative responses to violence against women through timely and meaningful consultation with equality-seeking groups. The groups should be provided with funding to enable them to develop their expertise and provide the committee with input and assistance. This task force would be responsible for the screening of all legislative initiatives to determine their consistency with women's equality.
8. The Committee recommends that Parliament revisit the issue of gun control and introduce registration that will be stronger in the following specific ways: that gun ownership be reformed as a privilege, and not as a right; that the privilege of gun ownership not be granted to persons who have been convicted of crimes against the person or other serious offenses; that the minimum age for gun ownership be raised from sixteen to eighteen years; that semi-automatic weapons be made restricted weapons; that all weapons be required to be registered by type and serial number on the owners firearms acquisition certificate (FAC); that a FAC be required for the purchase of ammunition; that a national database of gun owners and guns be set up; that women and non-gun owners be included in the process of defining safe storage requirements for guns and that the safe storage requirements be enforced; that all assault weapons be removed from circulation; and that the necessary resources be allotted to each of these initiatives.
9. The Committee recommends that the federal government take a leadership role and work with women's groups across the country and with the provinces to establish a royal commission on violence against women.

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### **6.2.2. Ad Hoc FPT Working Group Reviewing Spousal Abuse Policies and Legislation (2003)<sup>409</sup>**

The Federal/Provincial/Territorial Ad Hoc Working Group Reviewing Spousal Abuse Policies and Legislation was established in 2000 at the direction of the federal, provincial, and territorial

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<sup>409</sup> "Final Report of the Ad Hoc Federal–Provincial–Territorial Working Group Reviewing Spousal Abuse Policies and Legislation," prepared for the Federal–Provincial–Territorial Ministers Responsible for Justice (2003), <https://www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/pol/index.html>.

ministers responsible for justice. It was co-chaired by the Department of Justice Canada and the Nova Scotia Department of Justice. The working group was directed to review the implementation and status of mandatory/pro-charging and pro-prosecution policies for spousal abuse as well as proposed legislative reforms. Its first report, issued in 2001, focused on Criminal Code reforms and recommended amendments regarding breaches of court orders. Its second report, focused on spousal abuse policies, was issued in 2003. This was the first coordinated review of these policies across Canada.

The Working Group noted that the pro-charging and pro-prosecution policies for spousal abuse are the applicable standard for all criminal conduct, and the need to create specific policies in the spousal abuse context reflected the historical treatment of spousal abuse as a private matter. The Final Report reviewed the adoption of spousal abuse policies in Canada since 1981, reviewed the experiences of police, Crown prosecutors and victims, and focused on three objectives: criminalizing spousal abuse; promoting victim safety and security; and maintaining confidence in the administration of justice. The Working Group recommended the continued retention of pro-charge/pro-prosecution policies. It concluded that the charging policies had some unintended negative consequences, but they were strongly supported by the majority of victims and had contributed significantly to strengthening the criminal justice system response to spousal abuse. The Report also reviewed other measures that had been implemented to support these policies and better protect victims. It noted that ongoing training for criminal justice personnel and evaluation of new measures are critical to the effective response of the criminal justice system to spousal abuse.

The Working Group called for coordination in each jurisdiction across policy sectors and at the provincial, community, and individual levels, stating:

The essential ingredients of an effective strategy addressing domestic violence within each jurisdiction include resources, a focal point of leadership and co-ordination, senior-level commitment and support to undertake these initiatives, and an accountability framework based on commitment to a long-range vision.<sup>410</sup>

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 1) The Working Group recommends the retention of the current pro-charging policies for spousal abuse cases. In this regard, the current test should continue to apply, namely that a charge should be laid where there are reasonable grounds to believe that an offence has been committed and, in jurisdictions with Crown pre-charge approval, when it is in the public interest to lay a charge.
2. (Recommendation 3) The Working Group also recommends that the elaboration of pro-charging policies for spousal abuse specifically address, at a minimum, the following key issues:

**Test not met:** Where there are no reasonable grounds to believe that an offence has been committed but police nonetheless believe that the victim's safety may be at risk, police should consider the availability of other responses, including civil protection orders under provincial and territorial legislation on domestic violence and recognizance orders under section 810 of the Criminal Code. However, these alternative responses should not be used in place of charges where the test has been met.

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<sup>410</sup> "Final Report of the Ad Hoc FPT Working Group," p. 83.

**Arrest:** The pro-charging policy should not be viewed as modifying the standard criteria used to determine whether the circumstances of the case require the arrest of the offender. All of the circumstances should be evaluated before police decide to arrest, with or without a warrant.

**Dual charges:** Where the facts of a particular case initially suggest dual charges against both parties, police should apply a “primary aggressor” screening model, seek Crown review and approval of proposed dual charges for spousal violence, or do both.

**Pre-charge diversion to alternative justice processes:** The majority of the Working Group recommends against pre-charge diversion of spousal abuse cases to any alternative justice processes. The minority (British Columbia and Prince Edward Island) only allow pre-charge diversion of spousal abuse cases to Alternative Measures programs established pursuant to the Criminal Code on Crown approval.

**Investigation:** Attending police must be directed to conduct a complete investigation and to collect all available evidence from all sources and not just from or primarily from the victim.

**Risk assessment:** When conducting any risk assessment, police should apply validated tools to assess the safety and security of the victim throughout the process, including for bail purposes. Police should be supported in this regard through on-going training and education regarding risk assessment in spousal abuse cases.

**Release of an accused from custody by the officer in charge:** In assessing whether there are reasonable grounds to believe that the accused should not be released, the safety and security of the victim should be paramount. The officer in charge should consider whether there is a history of abuse, including previous breaches of bail or probation conditions, and criminal or civil court orders. Where the decision is made to release the accused, the officer in charge should require the accused to enter into an undertaking that includes appropriate conditions such as non-communication, non-attendance (for example, at residence, schools, and place of employment), firearms and drug and alcohol prohibitions. The victim should be advised of the decision to release an accused from custody and of any applicable conditions.

**Victim support:** Police should be required to advise of and direct victims to available victim services and other supporting agencies (such as shelters).

3. (Recommendation 8) It is recommended that jurisdictions support and strengthen, with senior-level commitment, co-ordination of initiatives to respond to family violence within and outside departments of justice that include multiple government and community stakeholders. Models of co-ordination may differ among jurisdictions but should incorporate the key elements of an effective response identified below. An effective coordinated response requires leadership and a focal point of coordination of government family violence initiatives with:

- authority to shape policy development to achieve a co-ordinated and consistent policy framework among a variety of departments;
- representation by all affected departments at senior levels by people with the ability to influence departmental policy and who have access to the Deputy Minister;
- resources to implement a co-ordinated policy framework;
- an accountability framework with mechanisms to track and report on progress;
- some form of representation and involvement or partnership with community stakeholders with roles of parties clearly defined;
- processes to enhance relationship-building at all levels among all players, and to promote a sense of partnership and a shared vision based on a common understanding of the problem;

- encouragement of local inter-sectoral committees;
  - support at a local level for government staff in the field, who implement provincial and territorial policy and who participate meaningfully in interagency forums to create positive working relationships and solutions to problems identified; and
  - some joint case management function across agencies to develop co-ordinated case plans for individual families where abuse is a concern (that is, protocols governing exchange of information and service provision; and roles and ways of working together).
4. (Recommendation 10) It is recommended that jurisdictions consider whether the adoption of civil domestic violence legislation would provide more immediate and broader remedies than presently exist, for example, under the Criminal Code. Of particular importance are provisions granting to the victim exclusive occupation of the home, temporary possession of personal property, temporary care and custody of the children, and a specific prohibition against selling, converting, or damaging property. Provisions directing removal of the abuser and seizure of weapons are also important. In jurisdictions where it has been enacted, civil domestic violence legislation is not to be used as a replacement for criminal charges where reasonable grounds exist for such a charge. However, criminal and civil process may be used concurrently. The following critical success factors should guide the implementation of the legislation:
- training should be conducted well in advance of the proclamation of this legislation and should include the information about its relationship to the Criminal Code;
  - attention should be paid to the importance of garnering community and stakeholder support;
  - mechanisms and co-ordinating committees should be implemented to ensure that problems such as training or interpretation issues are identified and addressed early;
  - the legislation should be closely monitored and evaluated, a task that should include developing methods for tracking breaches of the legislation;
  - public education should accompany the legislation to ensure that victims and the community are aware of it;
  - issues pertaining to the application of the legislation on reserve or settlement land should be addressed in consultation with Aboriginal communities to enlist their support to ensure the protection of victims and their children and to ensure the same degree of protection is available to individuals on- and off-reserve; and
  - provision of adequate legal aid resources will be required to assist women with the longer-term victim assistance orders, to make them effective remedies.
5. (Recommendation 11) It is recommended that jurisdictions, in collaboration with community agencies, continue to ensure the provision of support services to victims to assist them throughout their involvement with the criminal justice system. These services should include, at minimum:
- a. information about abuse, the criminal justice system, the role of the victim-witness, and case status;
  - b. referral and access to a range of supporting agencies and services to meet the multiplicity of victim needs;
  - c. victim notification of and participation in decisions regarding the release of accused individuals and offenders, and notification of conditions associated with the release;
  - d. emotional support and crisis intervention;
  - e. assistance with victim impact statements; and
  - f. risk assessment and safety planning.
- g. Key components of an effective service are:

- h. intervention as soon as possible following the incident;
  - i. access and referral to a continuum of services;
  - j. services that recognize the unique needs of spousal/partner abuse victims;
  - k. collaboration and co-ordination among agencies providing services;
  - l. clarity of roles (between criminal justice-based victim services and community support agencies); and
  - m. availability of information and effective communication mechanisms among players within and external to the justice system.
6. (Recommendation 12) It is recommended that jurisdictions explore ways to ensure the provision of a continuum of accessible, comprehensive, and co-ordinated community-based and government services to victims and their families, including both shelter and outreach services. Training for criminal justice professionals and service providers in a variety of disciplines serving abused women and their children is necessary to strengthen working relationships, to understand differing objectives, and to implement an effective response. Services required include the following:
- a. emergency access to a safe place (including emergency transportation and overnight accommodation, particularly for those in rural and isolated areas);
  - b. counselling and emotional support (immediately following a crisis and through follow-up and outreach on a residential or non-residential basis);
  - c. information and referral;
  - d. access to affordable and safe housing, and to legal and medical services;
  - e. employment and income support;
  - f. mental health and addiction services where required;
  - g. childcare, child support, and counselling for children to overcome trauma;
  - h. safety planning; and
  - i. assistance with the family law system (spousal maintenance, custody and access, child support and accommodation).
7. (Recommendation 15) It is recommended that the use of validated risk assessment tools be recognized as a way to help people make decisions at various stages of the justice system. It is recommended that jurisdictions further explore the use of risk assessment tools and exercise caution when offering guidelines for intervention based on the results of their use. Any related training should communicate the limitations associated with risk assessment tools.
8. (Recommendation 16) It is recommended that jurisdictions develop and enhance mechanisms for monitoring justice system performance in family violence cases, to support sound executive decision-making and measure the impact of new initiatives. It is recommended that jurisdictions support the development of information systems based on the collection of common key performance indicators to enable evaluation of justice system performance. The development of common methodologies for examining programs is also recommended (for example, when evaluating abusive partner treatment programs) to facilitate knowledge exchange and advancement. Elements of an effective response include the following:
- a. the use in all data collection systems of a family violence identifier to distinguish cases of spousal/partner abuse;
  - b. identification and collection of justice system key performance indicators (such as charge and arrest rates, “drop” rates, conviction rates, dispositions, duration of offender treatment and supervision, offender compliance with conditions, charges for noncompliance and rates of reoffending) to enable comparisons both within and between jurisdictions;

- c. capacity to produce management reports on justice system performance (byproducts of operational systems) for executive decision-making purposes;
  - d. information system integration (from police to courts to corrections) so that individual cases can be tracked; use of research to inform policies and practices; and
  - e. performance management to ensure that frontline workers comply with policy and procedures.
9. (Recommendation 17) It is recommended that each jurisdiction develop and implement a plan for the development and ongoing delivery of cross-sectoral training to new and existing staff dealing with family violence issues within the criminal justice system. This training should be based on the critical success factors identified below to ensure an effective response to family violence. It is suggested that jurisdictions share training resources to avoid duplication of effort and to minimize the burden of developing course material. The work of the National Judicial Institute should be supported to ensure that the judiciary continues to receive education regarding the dynamics of spousal/partner violence and the impact of the criminal justice response. The following best practices have been identified:
- a. integration of domestic violence training into pre-service training and additional annual training sessions to update information;
  - b. assignment of training co-ordination to a specific individual or group;
  - c. content that addresses information about the dynamics of family violence, the legislative remedies and options available—both criminal and civil—and the interplay between them, and the unique roles of particular parties (case studies are a useful method to “test” the learner’s ability to apply the policies and procedures, as well as to create a common understanding of “real-life situations” and the approaches to be used);
  - d. specialized training for police and Crown Prosecutors on evidence collection and prosecution of domestic violence cases;
  - e. specialized training regarding the dynamics of spousal violence for correctional services officials;
  - f. a train-the-trainer approach, which facilitates training of large numbers in a cost-effective manner;
  - g. training that underscores the partnership between people with expertise in family violence and people with knowledge of the particular sector or profession to be trained, ensuring a sound foundation for the development of the training content and the delivery strategy; and
  - h. provision of training at the local level to build on resources available in the community, since successful training initiatives involve criminal justice professionals together with community representatives, in order to emphasize the community–justice partnership (training is not only a means to impart information but also a process of building community capacity and of enhancing critical relationships among players—an approach that contributes to a common understanding of the problem and of the appropriate means of intervention, as well as to a shared sense of responsibility).
10. (Recommendation 18) It is recommended that resources at the government, corporate, and community levels be committed to broad-based prevention activities. An effective preventive strategy must address all stages of the continuum of family violence and include the following:
- a. programs for children and youth exposed to family violence or exhibiting aggressive behaviour;
  - b. school-based healthy relationship courses to teach the elements of healthy relationships and acceptable and unacceptable behaviour to both adolescent boys and girls as they begin to date, and to teach the concept of respect for others and conflict

- resolution techniques in earlier grades, as well as anti-violence campaigns and programs, including sexual assault and harassment prevention;
- c. public education to change attitudes, which contribute to the continued existence of family violence, in order to help victims identify abusive behaviour, to inform them of assistance available, and to encourage individual and community action;
  - d. early intervention measures, which seek to intervene early in relationships before abuse escalates to prevent further harm; and
  - e. programs that enable abusive partners to address their abusive behaviour, preventing further harm to others.

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### **6.2.3. Aboriginal Women and Family Violence (Indian and Northern Affairs Canada, 2008)<sup>411</sup>**

This report is a condensed version of a 2006 report prepared by the Ipsos-Reid research firm for Indian and Northern Affairs Canada. The introduction noted that no comprehensive studies had detailed the scope of family violence within Indigenous communities. The authors held focus groups with groups of First Nations and Métis women in four locations in Canada (including Sydney, Nova Scotia), and conducted telephone interviews with fifteen “first responders” representing RCMP and provincial police agencies, health care workers, social workers, and crisis centre staff. Five of these first responders worked with Inuit women in the north, and the remainder worked with First Nations women living on reserve and in urban centres in Southern Canada. Many of the focus group participants had personal experience with intimate partner violence.

The authors noted that first responders expressed the perception that there is a higher incidence of intimate partner abuse in Indigenous communities than elsewhere. Participants identified many causal factors for violence, including loss of identity and way of life and the continued impact of residential schools. Nearly all participants pointed to drug and alcohol consumption by both parties as an aggravating factor. Despite the significant consequences to women and children of this violence, the criminal justice system response was viewed as minimal and ineffective.

The report listed suggestions made by the focus group participants and first responders that would allow Indigenous women and first responders to become better informed about the problem of male violence against Indigenous women and improve first responders’ ability to assist. There is no information suggesting any government response to this report.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission<sup>412</sup>**

1. Increased funding for resources to assist Aboriginal women victims of male violence, encompassing:
  - a. Educational programs to teach Aboriginal women about healthy relationships;
  - b. Short-term and long-term housing for victims
  - c. Short-term and long-term counselling for victims
  - d. Counselling and provision of basic resources (e.g., food and clothing) for children;

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<sup>411</sup> “Aboriginal Women and Family Violence,” Indian and Northern Affairs Canada, National Clearinghouse on Family Violence (2008), [https://www.talk4healing.com/files/9413/5057/1341/Aboriginal\\_Women\\_and\\_Family\\_Violence.pdf](https://www.talk4healing.com/files/9413/5057/1341/Aboriginal_Women_and_Family_Violence.pdf).

<sup>412</sup> The recommendations were not numbered in the Report.

- e. Interim financial assistance for victims
  - f. Affordable transportation to available services
2. Emergency 24-hour, 7-day crisis hotlines
  3. 24-hour, 7-day access to assistance from first responders within reasonable proximity to communities
  4. Increased convenience and privacy in reporting acts of violence on reserves and in settlement communities
  5. Cultural sensitivity training for all first responders (police, health care professionals, educators and others who directly assist women victims of intimate partner violence or otherwise work with communities to reduce the incidence of such violence)
  6. Strong incentives or mandatory training for community leaders to ensure that they treat the issue of male violence against women as a high priority and a serious community-wide problem
  7. A “piggy-back” use of existing programs (such as Friendship Centres and medical facilities) or government-sponsored mailings (such as regular mailings of payments) to provide information on this issue and spare women from having to seek it out
  8. Training for personnel dealing with victims of abuse about privacy issues and the consequences of failing to respect the confidentiality of women dealing with this sensitive issue in communities with tight and overlapping familial ties

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#### **6.2.4. Ending Violence Against Aboriginal Women and Girls: Standing Committee on the Status of Women (House of Commons Committee, 2011)<sup>413</sup>**

The Standing Committee on the Status of Women issued this Report in 2011. The stated focus was to empower young Aboriginal girls and women with the goal of reducing the victimization, poverty, prostitution, and abuse they experience. The Committee heard from several Indigenous women’s organizations, VAW advocates, government officials, RCMP representatives, representatives from Friendship Centres, Indigenous community leaders, and academics. The New Democratic Party (NDP) and Liberal members of the Committee issued dissenting opinions, and the NDP issued its own set of recommendations.

#### **Recommendations Relevant to the Mandate of the Mass Casualty Commission<sup>414</sup>**

- (page 16) The Committee recommends that the federal government collaborate with the Native Women’s Association of Canada to explore the feasibility of i) sharing some or all of the information in the database with the Royal Canadian Mounted Police Support Centre for Missing Persons; and ii) deciding what if any information can ethically be made available more broadly beyond police and justice system officials.
- (page 19) The Committee recommends that the federal government, under the aegis of the Family Violence Initiative, work with the Canadian Police College, Aboriginal women’s

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<sup>413</sup> “Ending Violence Against Aboriginal Women and Girls: Empowerment, a New Beginning—Report of the Standing Committee on the Status of Women,” House of Commons (December 2011), <https://publications.gc.ca/site/eng/9.572804/publication.html>.

<sup>414</sup> The recommendations were not numbered.

organizations, and the Department of Public Safety Canada to develop and disseminate training materials with respect to the cultural and historical context in which violence against Aboriginal women occurs.

- (page 20) The Committee recommends that the federal government, under the aegis of the Family Violence Initiative, work with the Canadian Association of Chiefs of Police, Aboriginal women's organizations, Status of Women Canada, Aboriginal Affairs and Northern Development Canada, and the Department of Public Safety Canada to pilot and disseminate results of collaborative approaches at the community level to violence against Aboriginal women.
- (page 21) The Committee recommends that the federal government continue to work with its provincial and territorial partners and stakeholders to determine what more can be done within existing service models to better address the needs of Aboriginal victims of violence.

### **Recommendations of the NDP Dissenting Opinion Relevant to the Mandate of the Mass Casualty Commission**

- (page 60) New Democrats recommend that the Government of Canada, in collaboration with Aboriginal, Inuit, and Métis women's organizations, provincial and territorial governments, address violence against Aboriginal women through coordinated, strategic interventions on a number of fronts, including but not limited to: poverty, child welfare, education, housing, missing and murdered Aboriginal women, the justice system, healing of communities, families and individuals, empowering Aboriginal women, and dealing with the impacts of systemic racism.
- (page 60) New Democrats recommend that the Government of Canada designate stable funding for programs and non-governmental Aboriginal organizations across the service spectrum.
- (page 60) New Democrats recommend that the Government of Canada implement a coordinated, collaborative, national housing strategy to combat violence against Aboriginal women. The Committee heard that the unmet housing needs of Aboriginal women are correlated to a greater risk of violence.
- (page 62) New Democrats recommend that Statistics Canada and the Royal Canadian Mounted Police—in collaboration with the Native Women's Association—work to reform data collection techniques to identify victims of violence by gender and, specifically, if applicable, as Aboriginal.
- (page 62) New Democrats recommend that the Royal Canadian Mounted Police and the Department of Justice Canada ensure that its employees receive specialized cultural sensitivity training—that has been developed in collaboration with Aboriginal organizations—on how to handle cases of violence against Aboriginal women. We further recommend that Aboriginal police forces receive specialized training on how to proceed with missing persons, domestic violence, and violence in all its forms.
- (page 63) New Democrats recommend that the Government of Canada take immediate steps to implement the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) recommendations on violence against Aboriginal women.
- (page 63) New Democrats wish to acknowledge that the lasting effects of racism perpetrated against the first peoples of Canada are among the root causes of the violence that afflicts Aboriginal women.

- (page 63) New Democrats further recommend that Canada implement without delay the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).
- (page 64) New Democrats recommend that the Department of Aboriginal Affairs and Northern Development Canada, in collaboration with other government departments and agencies, report annually to Parliament on the effectiveness of federal government programs in reducing violence against Aboriginal women and request from time to time that this report be evaluated by the Auditor General.

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### **6.2.5. Invisible Women: Special Committee on Violence Against Indigenous Women (House of Commons, 2014)<sup>415</sup>**

This Special Committee was created in 2013 following a unanimously passed motion in the House of Commons recognizing the disproportionate number of Indigenous women and girls who had suffered violence, been murdered, and/or gone missing in the previous three decades. The mandate of the Committee was to conduct hearings on this issue and propose solutions to address the root causes of the violence. The Committee heard from families and individuals, Indigenous organizations, police representatives, VAW advocates, child welfare officials, and government officials. (The Native Women's Association of Canada (NWAC) apparently withdrew from the Committee's process in the fall of 2013.) The Committee tabled its Report to the House of Commons in March 2014, with dissenting opinions from the Liberal and NDP members of the Committee. The Report opened by referring to the wishes expressed by many families and witnesses who appeared before the Committee that the Report include recommendations that would make a real difference in the lives of Indigenous women and girls, and not recommend yet more study.

#### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

- (Recommendation 1) That the federal government learn from the stories of the families of missing and murdered Aboriginal women and girls and work with the provinces, territories, and municipalities to create a public awareness and prevention campaign focusing on violence against Aboriginal women and girls in Canada.
- (Recommendation 3) That the federal government maintain its commitment to develop the Canadian Victims Bill of Rights, including initiatives aimed at making the criminal justice system more responsive to the needs of victims, such as keeping them informed and providing them with appropriate standing, access, and assistance throughout the process.
- (Recommendation 6) That the federal government continue to support programming and legislation that allow Aboriginal communities to respond to violence.
- (Recommendation 8) That the federal government engage First Nation communities to examine how to improve supports for shelters and frontline services on reserve for victims of violence.

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<sup>415</sup> "Invisible Women: A Call to Action—A Report on Missing and Murdered Indigenous Women in Canada," Special Committee on Violence Against Indigenous Women, House of Commons (March 2014), <https://www.ourcommons.ca/Content/Committee/412/IWFA/Reports/RP6469851/IWFArp01/IWFArp01-e.pdf>.

- (Recommendation 10) That the federal government in cooperation with municipal, provincial, and territorial governments examine the possibility of collecting police data on violence against Aboriginal women and girls that includes an ethnicity variable.
- (Recommendation 11) That the federal government engage Aboriginal communities and municipal, provincial, and territorial governments to examine options to improving procedures among police services to facilitate multipartite investigations.
- (Recommendation 12) That the federal government encourage Aboriginal organizations, the Canadian Police College, and municipal, provincial, and territorial governments to improve police officer training, including continuing education, to foster cultural understanding and sensitivity.
- (Recommendation 16) That the federal government implement all of the recommendations above in a coordinated action plan.

### **Recommendations of the NDP Dissenting Opinion Relevant to the Mandate of the Mass Casualty Commission**

1. That the federal government establish a National Commission of Public Inquiry to analyse violence against Indigenous women and girls, in particular those who are missing or have been murdered; and that where possible, Indigenous women are involved in the design, decision-making process and implementation of this inquiry.
2. That the federal government, based on the motion presented to the House by Niki Ashton (M-444) and with leadership from Indigenous communities, specifically Indigenous women and their representatives, develop and implement a national action plan to address violence against Indigenous women and girls that addresses the structural root of the violence as well as the accountability and coordination of government bodies charged with preventing and responding to violence.
3. The federal government should take all efforts to enable Indigenous women as leaders in any strategy to reduce violence or to promote gender equality. This may include consultation in program design and implementation with sustainable and predictable project funding specifically for Indigenous women to combat violence at the national, regional, community, and family levels.
4. That the federal government address chronic underfunding of:
  - a. frontline services;
  - b. housing;
  - c. child welfare services;
  - d. education;
  - e. health and mental health treatment;
  - f. safe houses, especially in northern and remote communities;
  - g. research, advocacy organizations, and data collection;
  - h. other anti-poverty programming

for all Indigenous women, their families, and communities, in close consultation with Indigenous peoples and while respecting Canada's obligations in section 35 of the Constitution Act 1982 and under the UNDRIP.
5. That the federal government invest in a balanced, effective approach based on prevention, policing, and prosecution to address violence against Indigenous women and girls by providing sustainable and ongoing funding for: preventive, anti-violence, and community

safety initiatives; police services in Inuit, First Nations, and Métis communities; and victim and healing programs; and also by developing police officer training to counter racism and sexism in the treatment of Indigenous women and girls, in close consultation with Indigenous peoples and while respecting Canada's obligations in section 35 of the Constitution Act 1982 and under the UNDRIP.

### **Recommendations of the Liberal Party Minority Opinion Relevant to the Mandate of the Mass Casualty Commission**

- (Recommendation 1) The Liberal Party of Canada recommends that the Government of Canada call a national public commission of inquiry into the issue of missing and murdered Indigenous women and girls. That national public commission of inquiry must have the scope and resources necessary to identify the root causes of this ongoing tragedy, provide justice for the victims and true healing for their loved ones.
- (Recommendation 2) The Liberal Party of Canada recommends the immediate development and implementation of a national action plan to address violence against Indigenous women and girls, the structural root causes of that violence, and the coordination and accountability of government bodies charged with preventing and responding to the violence. The Liberal Party of Canada further recommends that a committee of cabinet be established that will be responsible for the creation of such a national action plan in close consultation with Aboriginal leadership and communities and that a progress report of the work of this cabinet committee be tabled with Parliament no later than June 21, 2015.
- (Recommendation 4) That the federal government, with leadership from Aboriginal communities, develop a working group on violence against Aboriginal women and children, comprised of relevant government departments (including Public Safety Canada, Aboriginal Affairs and Northern Development Canada, Status of Women Canada, and Health Canada), and national Aboriginal organizations, including the Native Women's Association of Canada; that this working group be tasked with collectively developing a coordinated strategy to prevent and address violence against Aboriginal women and girls; and that the working group report to Parliament on its progress no later than June 30, 2015.
- (Recommendation 5) That the federal government, in collaboration with Aboriginal organizations, create a national public awareness and prevention campaign focusing on violence against Aboriginal women and girls in Canada.
- (Recommendation 6a) That the federal government support a national meeting led by the families of missing and murdered Aboriginal women.
- (Recommendation 6b) That the federal government create a fund to help the families of missing and murdered Aboriginal women and girls that have incurred expenses related to the loss of their loved ones.
- (Recommendation 7) That the federal government invest more resources in the program administered by Public Safety Canada that allows Aboriginal communities to develop safety plans and establish emergency management teams to respond to violence.
- (Recommendation 9) That the federal government provides adequate investment in shelters and frontline services for victims of violence to create new shelters and to ensure that funding of existing shelters is comparable to off-reserve shelters.
- (Recommendation 13) That the federal government, in collaboration with provincial and territorial governments, increase funding for police services in Inuit and First Nations communities.

- (Recommendation 14) That the federal government, in collaboration with Aboriginal organizations and provincial and territorial governments, examine the possibility of collecting police data on violence against Aboriginal women and girls that includes an ethnicity variable.
- (Recommendation 15) That the federal government, in collaboration with Aboriginal organizations and provincial and territorial governments, develop procedures among police services to facilitate multipartite investigations.
- (Recommendation 16) That the federal government, in collaboration with Aboriginal organizations and human rights advocacy organizations, the Canadian Police College, and provincial and territorial governments, develop police officer training and protocols, along with serious consequences for failing to abide by them, in order to counter racism and sexism in the treatment of Aboriginal women and girls.

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### **6.2.6. Promising Practices to Prevent Violence Against Women and Girls: Standing Committee on the Status of Women (House of Commons, 2015)<sup>416</sup>**

The House of Commons' Standing Committee on the Status of Women studied promising practices to prevent violence against women and girls and issued its report in June 2015. The Liberal and NDP members of the Committee each issued a dissenting opinion. The Committee held eleven meetings and heard from 48 witnesses. The Committee referred to violence affecting 1090 of every 100,000 women in Canada (apparently confusing the yearly rates of violent victimization for women with lifetime rates).<sup>417</sup> The Report identified the causes of violence against women and girls as rooted in women's inequality, harmful concepts of masculinity that reinforce violence as a part of boys' lives, the history of colonial violence and community trauma in Indigenous communities, and particular vulnerabilities such as homelessness, poverty, substance abuse, immigration status, employment in sex work, and disability.

#### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

- (Recommendation 1) The Committee recommends that the Government of Canada work with organizations to utilize proven best practices to prevent violence against women and girls.
- (Recommendation 2) The Committee recommends that Status of Women Canada ensure that preventing violence against women and girls continues to be a priority.
- (Recommendation 3) The Committee recommends that the Government of Canada act on the policies and programs in place that are centred on prevention and education in efforts to prevent violence against women and girls, emphasizing best practices.
- (Recommendation 4) The Committee recommends that the Government of Canada continue to fund projects through Status of Women Canada in efforts to prevent violence against women and girls.

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<sup>416</sup> "Promising Practices to Prevent Violence Against Women and Girls: Report of the Standing Committee on the Status of Women," House of Commons (June 2015), <https://www.ourcommons.ca/Content/Committee/412/FEWO/Reports/RP8021724/feworp07/feworp07-e.pdf>.

<sup>417</sup> The Report referred to "the violence that affects 1,090 of every 100,000 women in the Canadian population" ("Promising Practices," p. 5) and later referred to Statistics Canada data showing that in 2013, "the rate of violent victimization was 1,090 female victims for every 100,000 women in the population" (p. 8).

- (Recommendation 5) The Committee recommends that the Minister of Status of Women work toward putting the issue of sexual violence and assault on the next federal/provincial/territorial meeting agenda.
- (Recommendation 6) The Committee recommends that the Government of Canada continue to support efforts to engage men and boys in preventing violence against women and girls.
- (Recommendation 8) The Committee recommends that Status of Women Canada continue its practice of issuing Calls for Proposals on preventing violence against women and girls, with a focus on Aboriginal Women.
- (Recommendation 9) The Committee recommends that the Government of Canada continue to support the implementation of the Action Plan to Address Family Violence and Violent Crimes Against Aboriginal Women and Girls.

### **Recommendations of the NDP Minority Opinion Relevant to the Mandate of the Mass Casualty Commission<sup>418</sup>**

- That the Government of Canada develop a comprehensive National Action Plan on Violence Against Women with adequate human and financial resources, in collaboration with provincial, territorial, and municipal governments, civil society, and First Nations, Métis, and Inuit peoples, with clear goals, measurable targets, and specific timelines as outlined in Motion M-444.
- That the Government of Canada establish a national inquiry into missing and murdered Indigenous women and girls and that, where possible, Indigenous women are involved in the design, decision-making process and implementation of this inquiry.
- That the Government of Canada work with provinces, territories, and Indigenous communities to create a universal early childhood and childcare program delivered with common principles like affordability, availability, and quality that costs no more than \$15/day per child.
- That the Government of Canada take steps to address the economic security of women and girls.

### **Recommendations of the Liberal Party Dissenting Opinion Relevant to the Mandate of the Mass Casualty Commission**

The Liberal Party opinion identified many of the majority recommendations as reinforcing the status quo or saying little. It described the Action Plan as a “laundry list of existing federal initiatives.” It also noted the lack of any recommendation to address poverty and the lack of affordable housing, shelters, and transition homes, which prevent women and children from leaving their abusers.

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<sup>418</sup> The following recommendations were not numbered in the Standing Committee Report.

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### 6.2.7. Reclaiming Power and Place: National Inquiry into Missing and Murdered Indigenous Women and Girls (2019)<sup>419</sup>

From 2016 to 2019, the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG) examined the systemic causes of all forms of violence against Indigenous women and girls in Canada, as well as the institutional policies and practices implemented in response to this violence. The Inquiry heard from hundreds of survivors and their family members, expert witnesses, Elders and Knowledge Keepers, frontline workers, and officials. It concluded that the violence perpetrated against women, girls, and 2SLGBTQIA people amounts to genocide and has been empowered by colonial structures.

The MMIWG Inquiry adopted a broad definition of violence, including emotional, psychological, spiritual, cultural, and financial violence, and neglect. It also included colonial and institutional violence.<sup>420</sup>

The Report explained the central role that women played in Indigenous communities prior to colonization. Women were engaged in hunting, farming, harvesting, trade, and other land-based and economic labour; they also had significant roles in cultural practices. Female kinship was particularly significant in Métis communities. Women also had significant leadership and decision-making roles prior to colonization. Gender was also understood as being fluid; in many communities, gender-diverse people were respected and same-gender relationships were common. While there was gendered violence in Indigenous communities, it was subject to strong taboos. Punishment included expulsion or banishment. “While traditions vary, what they have in common is that the strict level of social control exercised by women through governance within their own communities meant that redress—and justice—could be found.”<sup>421</sup>

The Report also described Indigenous laws and legal principles, noting that they are rooted in the principles of respect, reciprocity, and interconnectedness. It quoted Indigenous legal scholar Val Napoleon as follows:

The issue of missing and murdered Indigenous women and girls is not only a legal issue within Canadian law. It’s an issue within our different Indigenous legal orders. And the work of Indigenous law includes that of rebuilding citizenries and rebuilding our lawfulness.<sup>422</sup>

These laws, and the rights articulated within them, were identified as having potential to promote safety and justice in ways that are not oppressive, colonial, or exclusionary. However, these laws, which were the foundation of teachings on rights, roles and responsibilities in Indigenous communities, have been fundamentally undermined through colonization, which in turn has undermined the humanity of Indigenous Peoples

The Report reviewed the history of colonization in Canada, noting that this process attempted to alter the identities and community roles of Indigenous women and 2SLGBTQIA people. For example, the Indian Act and resulting restructuring of homelands often led to the separation of communities from each other and the splitting of extended families into smaller households. This

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<sup>419</sup> “Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls” (June 2019), <https://www.mmiwg-ffada.ca/final-report/>.

<sup>420</sup> For definitions of these forms of violence, see “Reclaiming Power and Place,” Volume 1a, pp. 76–78.

<sup>421</sup> “Reclaiming Power and Place,” Volume 1a, p. 167.

<sup>422</sup> “Reclaiming Power and Place,” Volume 1a, p. 139.

in turn removed family systems that had promoted the safety of women and families for generations.

The Report also examined the ways in which the residential schools system helped to erode the safety of Indigenous women and girls. The schools' focus on the Christian patriarchal system meant that girls were encouraged to leave school early to focus on domestic work and were not equipped for anything other than working in the home or low-paying jobs, even if they completed school. The segregation of girls and boys, the denial of spiritual and cultural teachings about respectful relationships, and the stigmatizing of puberty and sexuality inhibited the development of healthy gender relationships. At the same time, rampant sexual abuse in these schools victimized generations of children and normalized their experiences of violence for the rest of their lives, making them more vulnerable to future violence. Victims went on to struggle to raise their own families, and some survivors turned into abusers, returned to their communities, and abused others. Children of murdered and missing Indigenous women were much more likely to be sent to residential schools or foster homes, compounding the effects of these tragedies. Forced sterilization of those deemed "mentally defective," which was practiced across the country in the 1920s and 1930s, disproportionately targeted Indigenous women. This was another form of direct state violence against these women, adding to their dehumanization and objectification. The "Sixties Scoop," which extended into the 1990s and led to the removal of thousands of Indigenous children from their homes through the child protection system, replicating the trauma of family separation, assimilation, abuse, and trauma of the residential schools system. These children often ran away and lived on the streets, where they were vulnerable to more violence. The Report emphasized that the absence of women and girls in Indigenous communities places family members, entire communities, and Nations at risk. "[W]omen as teachers, leaders, healers, providers and protectors were and remain indispensable parts of the equation to generation solutions for the crisis of missing and murdered Indigenous women and girls."<sup>423</sup>

The Report reviewed the ways in which colonial destruction of cultural practices, social inequality, barriers to education and training, poverty, and the lack of equitable access to health care have also affected the safety of Indigenous woman and girls. In turn, some women, girls, and 2SLGBTQIA people decide to move in order to escape violence, poverty, or abusive partners or foster placements; some are teenagers who have "aged out" of foster care and have nowhere to go. They often have no access to safe transportation and are forced to resort to hitchhiking or walking, placing them at further risk of violence. They may end up at shelters or living on the streets, where they are vulnerable to predators and traffickers. As well, Indigenous women are often criminalized for protecting themselves and their children against violence.

The Report emphasized that these colonial policies and structures, and the ideas that fed them, are still present today:

The reality is that many of the people who testified before the National Inquiry have lived through, and continue to heal from, these policies. Many more people are in current conflict with them. Many of the policies and ideas in place today, as well as the structures they are associated with, are modern iterations of the same historical atrocities.<sup>424</sup>

The history of policing in Canada has had a significant role in reducing safety for women and girls. The North-West Mounted Police, the precursor to the RCMP, was created in 1873, combining military, police and judicial functions, with a mandate to clear the land still possessed by

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<sup>423</sup> "Reclaiming Power and Place," Volume 1a, p. 174.

<sup>424</sup> "Reclaiming Power and Place," Volume 1a, p. 312.

Indigenous people and to quash rebellions by them. In the next decade, this police force became very involved in regulating, segregating, brutalizing, and criminalizing First Nations and Métis women. Policies, laws, and politicians of the time cast Indigenous women as hypersexualized, suspicious, immoral, lazy, and dirty. Those stereotypes in turn justified the mistreatment and abuse of Indigenous women by police and non-Indigenous settlers, allowing police and others who raped or killed women to be immune from effective prosecution. The Report noted that “The early tone set by the nature and extent of the policing of Indigenous women, including abuse by the police, continues to permeate modern encounters with a deep sense of suspicion and distrust.”<sup>425</sup>

The Report identified a historical and continuing indifference on the part of police to reports of violence and abuse from Indigenous women and girls. That indifference has also manifested in the historic refusal to investigate the disappearances and deaths of many Indigenous women and girls. Many families reported that police responded to their reports with “[d]ismissal, contempt, and outright discrimination, in which police evoke racist stereotypes about Indigenous people as drunks, runaways, or prostitutes, and which ignore the insights that families bring them that something is wrong.”<sup>426</sup> This apathy on the part of the police sends the message that men who kill Indigenous women and girls will face no consequences for doing so, which may in turn increase the risks these women face. Women are also reluctant to report abuse to police due to a well-founded fear that child protection organizations will become involved and will remove their children. Fear of being accused of committing crimes themselves (dual arrests), as well as fear of excessive use of force, sexual harassment, and sexual assault by police also discourage women from reporting.

Police and RCMP representatives told the Inquiry that police abuses and failures to protect Indigenous women and girls were the results of single officers who fail to follow an adequate procedure rather than the result of the policing structure itself. In response, the Report quoted Farida Day of Human Rights Watch:

Generally, in our work on policing abuses in many countries, the response by the police is generally one of denial of the policing abuses taking place, claiming that there are just a number of bad apples on the police force, not a systemic issue, not a structural issue. They will often drown us in policing protocols and policies to show how, you know, advanced they are and how much in line they are with international standards. But our response is always that we’re not really concerned about the policies, we’re concerned about the practice and the implementation of those policies. And [...] even if we were to argue that it was a few bad apples, has there been accountability for those bad apples? Has there been any kind of—how have you used that as a teaching moment to change your training of the police services, to change your recruitment practices? What has happened since then?<sup>427</sup>

The Report also noted that although many officers encouraged families and survivors to report police abuses, this places the onus on Indigenous people to hold police accountable. This is impossible, given the barriers and power dynamics involved in interactions between Indigenous people and police.

The Report identified numerous specific problems with the police investigations of murdered and missing Indigenous women and girls, including delays in commencing investigations, accidental

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<sup>425</sup> “Reclaiming Power and Place,” Volume 1a, p. 258.

<sup>426</sup> “Reclaiming Power and Place,” Volume 1a, p. 650.

<sup>427</sup> “Reclaiming Power and Place,” Volume 1a, p. 654.

destruction of evidence, refusal of investigating officers or coroners to provide any information (to the point, in some cases, of threatening the family member if they continued to seek information), and confusion caused by the multiple agencies and departments involved. Although victim services programs were often described as helpful, providing support and advocacy for the families, access to these services has been inconsistent. Many families of murdered and missing Indigenous women and girls were not taken seriously or believed when they reported the disappearance of their loved ones and were discriminated against during the judicial process. Because the system did not value their loved ones, they had to become full-time advocates to get real investigations and real access to justice. This advocacy came at great cost, both in terms of time and emotion. The Report identified the inadequate responses of the police and justice system as a breach of domestic and international human rights law.

The Report noted that many representatives of police agencies, including Brenda Lucki of the RCMP, apologized to the Inquiry for the harm their agencies had caused and committed to change. The Report identified a number of initiatives, including changes in policy, the creation of Indigenous advisor committees for police agencies, recruitment of Indigenous police officers, and national policies and strategies on missing persons. However, police representatives also acknowledged that there remained serious challenges to providing equitable policing to all Indigenous people. The Report noted that the underlying reality is that the Canadian justice system and its conception of policing are at odds with Indigenous conceptions of justice, which are focused on responsibilities, relationships, and restoration rather than rights and punishment.

The Inquiry collected over 1200 recommendations from reports and commissions on the issue of combatting violence against women, girls, and 2SLGBTQQIA people. It noted that greater interjurisdictional cooperation is a crucial recommendation in these reports. For example, confusion and disputes between federal and provincial governments regarding their jurisdiction over issues relating to Indigenous peoples have created gaps in funding and services for Indigenous communities, which in turn lead to the targeting of and violence toward Indigenous women, girls, and 2SLGBTQQIA people. The Report referred to this as “jurisdictional neglect.”<sup>428</sup> The Report identified human trafficking and other crimes involving movement across jurisdictions as creating significant jurisdictional challenges. Investigation of these crimes can involve multiple police agencies, often including RCMP and provincial and municipal agencies, which must coordinate and share information.

The Report noted that 51 recommendations from 22 reports written between 2003 and 2016 called on provincial and/or federal governments to ensure that services and programs for Indigenous women were funded adequately and sustainably, and at levels equal to those provided to non-Indigenous women. The Inquiry reviewed recent funding decisions by various governments, and concluded that while some improvements have been made, “pledged amounts still fall short of Indigenous communities’ needs, and, in several areas, Indigenous Peoples still receive less funding compared with non-Indigenous people.”<sup>429</sup> For example, only 38 shelters were operational in the 634 recognized First Nations communities as of January 2018; Inuit women have even fewer shelters available to them. Counselling programs for women, men, and children have long waiting lists. Family members of murdered women and girls identified the lack of shelters and other services as contributing to their loved ones’ deaths. Few of these resources are culturally specific and do not serve the unique needs of Indigenous women. Many refuse to accept clients in active addiction or who are part of the sex trade, excluding many Indigenous

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<sup>428</sup> “Reclaiming Power and Place,” Volume 1a, pp. 561–62.

<sup>429</sup> “Reclaiming Power and Place,” Volume 1a, pp. 570–72.

women who cope with trauma, violence, and poverty this way. The Inquiry also learned that First Nations police services are chronically underfunded, impeding their ability to prevent crime and to investigate it.

The Report noted the legacy of racism and colonialism in numerous ways. In one instance, it referred to the inquest into the death of Victoria P. in Nova Scotia (presumably Victoria Paul, whose case is summarized above in section 2.1.4.). It noted that the president of the Nova Scotia Native Women's Association, who was an Indigenous woman, spent months trying to secure a review of the investigation by the Office of the Police Complaints Commissioner. However, government officials responded to her concerns only once she was accompanied by a respected and well-connected university professor.

The Inquiry issued numerous Calls for Justice. One of its interim recommendations was as follows:

That the federal government work collaboratively with provinces and territories to create a national police task force to which the National Inquiry could refer families and survivors to assess or reopen cases or review investigations.

In response, the federal government announced funding for the RCMP to provide national oversight to major RCMP investigations, including investigations into missing and murdered Indigenous women and girls. The Final Report emphasized that this announcement did not fulfill the recommendation:

We maintain that Canada needs an independent national police task force specifically designed to meet the needs of family members and survivors of violence against Indigenous women, girls, and 2SLGBTQQIA people, which would include non-police members and investigators, and other built-in, transparent oversight mechanisms.

Our most important objection to providing additional funding to the RCMP in this manner is that, once again, this involves police policing themselves. The RCMP have not proven to Canada that they are capable of holding themselves to account—and, in fact, many of the truths shared here speak to ongoing issues of systemic and individual racism, sexism, and other forms of discrimination that prevent honest oversight from taking place.

In addition, our recommendation was for a national police task force, whereas the government's response includes only the RCMP, which does not cover other police service investigations or areas covered by a national task force.

The National Inquiry is also concerned about the non-specific language used, in that "a significant portion" will go toward investigations of missing and murdered Indigenous women and girls. In 2010, the federal government cut funding to the Native Women's Association of Canada's "Sisters in Spirit" research, education, and policy initiative to provide additional funding to other departments and to the RCMP, where enhancements made were general and not specific to Indigenous women and girls. These actions don't inspire confidence for the future.<sup>430</sup>

The Inquiry made the following overall findings regarding the right to justice for Indigenous women, girls, and their families (quoted here in their entirety):

1. The Canadian justice system is premised on settler-colonial society's values, beliefs, laws, and policies. It is a justice system that fails to include Indigenous concepts of justice. The

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<sup>430</sup> "Reclaiming Power and Place," Volume 1a, pp. 70–71.

Canadian justice system has been imposed on Indigenous Peoples and has oppressed and replaced the Indigenous justice systems that served Indigenous communities effectively since time immemorial.

2. The government of Canada used the Royal Canadian Mounted Police (RCMP) and its predecessor, the Northwest Mounted Police, to implement and enforce laws and policies designed to control, assimilate, or eliminate Indigenous Peoples. On behalf of the Government of Canada, the RCMP ensured the forced relocations of Indigenous communities; removed children from their families and communities to place them in residential schools; enforced laws that prohibited traditional spirituality and ceremonies; enforced the Indian Act governance structures, including the pass system, at the behest of Indian agents; facilitated the apprehension of children during the Sixties Scoop; and enforced other discriminatory and oppressive legislation and policies.
3. This historic role of the RCMP has not changed significantly. The RCMP must still enforce present-day discriminatory and oppressive legislation and policies in areas such as child welfare and land and resource disputes.
4. The historic and present-day role of the RCMP, the continued racism and sexism by many RCMP officers directed at Indigenous Peoples, the high rates of missing and murdered Indigenous women, girls, and 2SLGBTQQIA people, and lack of resolve have caused many Indigenous peoples and communities to lose trust and confidence in the Canadian justice system, the RCMP, and police services in general.
5. The language used in the Canadian justice system, especially the language used in the Criminal Code and in criminal justice proceedings, minimizes the nature and severity of violent offences and serves to minimize the responsibility of the offender and the impact of the crime.
6. The Canadian criminal justice system fails to provide justice for Indigenous people, especially missing and murdered Indigenous women, girls, and 2SLGBTQQIA people. The system's failure to effectively hold accountable those who commit violence against Indigenous women, girls, and 2SLGBTQQIA people means that violence against Indigenous women, girls, and 2SLGBTQQIA people is met with impunity.
7. The failure of the Canadian justice system to protect Indigenous women, girls, and 2SLGBTQQIA people is well established and documented by the Royal Commission on Aboriginal Peoples and the Aboriginal Justice Inquiry of Manitoba [summarized above in section 2.2.1.]. The lack of effective response by the federal government, in particular, to remedy this failure, prevents the fundamental paradigm shift that is imperative to end the genocide.

### **Forensic Document Review Project (Police File Review)**

In addition to hearing testimony, the Inquiry engaged in a review of police files from across the country relating to missing and murdered Indigenous women, girls, and 2SLGBTQQIA people. This was referred to as the Forensic Document Review Project (FDRP) and was designed to identify and make recommendations relating to systemic problems, barriers, and weaknesses in the investigations of missing persons reports, suspicious or implausible deaths, and acts of violence against Indigenous women, girls, and 2SLGBTQQIA people. The Report explained that the number of police files it was able to subpoena and review was limited, given the length of the Inquiry's mandate period. Municipal and regional police forces generally cooperated with the FDRP, devoting extra resources and people to the task of complying with subpoenas in a timely way. However, the Report noted significant issues with the RCMP:

By contrast, the RCMP demonstrated reluctance to provide the FDRP with the information requested. The degree to which the RCMP, represented by the Department of Justice, resisted disclosure of the files sought by the FDRP created a challenge to its ability to obtain and review the necessary documents. Many of the files received contained redactions that rendered some documents unintelligible. This affected the analysis. This is particularly significant because the RCMP is the national police force responsible for policing approximately 40% of the Indigenous population and 39% of unsolved cases reviewed by FDRP.<sup>431</sup>

The FDRP identified the following systemic issues relating to policing across the country:

- a. There is no reliable estimate of the numbers of missing and murdered Indigenous girls, women and 2SLGBTQQIA people in Canada. The 2014 RCMP report on the issue concluded that there were 1,017 homicides and 164 disappearances of Indigenous women and girls between 1980 and 2012,<sup>432</sup> but there were serious shortcomings with the data the RCMP used to come to this conclusion, including inconsistencies with reporting the Indigenous identity of victims.
- b. The RCMP had concluded that the majority of murdered Indigenous women and girls were killed by Indigenous men who were known to them. However, there were serious flaws in the RCMP's analysis. This in turn affects the soundness of RCMP policy development. "A focus on spousal violence, on the basis of flawed statistics, has resulted in an erroneously narrow focus on Indigenous men as the perpetrators of violence against Indigenous women and girls, and neglects other significant patterns in relation to missing and murdered Indigenous women and girls in Canada."<sup>433</sup> It also contributes to bias, stereotyping, and racism, while ignoring violence perpetrated by non-Indigenous people against Indigenous girls and women.
- c. Indigenous communities, particularly in remote areas, are under-prioritized and under-resourced. The FDRP identified this issue as specific to RCMP services, noting that the RCMP system of rotating postings leads to young, inexperienced officers filling remote postings (which are considered less desirable), with significant turnover of investigators on unsolved death or missing persons cases. The use of central RCMP dispatchers in remote areas also leads to lower response times, even where the call comes from a location close to a detachment.
- d. There were repeated instances of failure by police officers to communicate information to family members of victims.
- e. Lack of communication and coordination between police and other service agencies was an issue in a number of files:

In a number of cases, there was evidence that the killer of an Indigenous woman or girl had a history of violence against the victim or other people. In some instances, that previous history of violence was not properly addressed. It is apparent to the FDRP that, at least in part, the failure to take adequate preventative measures was as a result of a profound indifference on the part of police. Better communication and coordination between the police and other

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<sup>431</sup> Vol 1b Annex 1, p.242

<sup>432</sup> "Missing and Murdered Aboriginal Women: A National Operational Overview," RCMP (2014), <https://www.rcmp-grc.gc.ca/en/missing-and-murdered-aboriginal-women-national-operational-overview>. See especially p. 20.

<sup>433</sup> "Reclaiming Power and Place," Volume 1b, Annex 1, p. 249.

service agencies in some instances potentially might have prevented the subsequent homicide of the victim.<sup>434</sup>

- f. The FDRP also identified several cases where child protection agencies had concerns about the safety of children which were not taken seriously by the police.
- g. Police often made investigative decisions based on prejudicial stereotypes and beliefs about Indigenous women and girls or Indigenous people in general, including assumptions that they would run away due to intolerable conditions on reserve or were likely to commit suicide. The indifference characterizing many of these investigations led to investigative errors, including the loss or destruction of evidence, delays in initiating investigations, failure to interview witnesses, obtain relevant evidence, and follow up leads. The FDRP also noted a significant number of cases in which the Crown accepted pleas to manslaughter where first- or second-degree murder charges appeared to be warranted.

The FDRP team reviewed dozens of prior inquiry reports, reviews, and other work examining policing in the context of missing and murdered Indigenous women and girls. It concluded that “[N]one of the issue the FDRP raises as significant are new but confirmed much of what families told us. Nothing will improve the current situation unless there is will to address the root cause of this ongoing crisis, the profound multi-institutional indifference toward violence directed at Indigenous women, girls, and 2SLGBTQQIA people.”<sup>435</sup> The FDRP made the following recommendations (quoted here in their entirety):<sup>436</sup>

- a. That in all the following recommendations, Indigenous women and 2SLGBTQQIA people play a central role in their development and implementation.
- b. That the FDRP should be continued. We recommend the creation of an independent, Indigenous-led national review body with the statutory powers to access all relevant information and to compel the testimony of any witness necessary to enable a complete review of all cases of missing and murdered Indigenous women and girls that will, among other things, determine the true numbers of and causes of violence against missing and murdered Indigenous women, girls, and 2SLGBTQQIA people.
- c. That the federal, provincial, and territorial governments create a permanent, national, Indigenous-led police task force for the purposes of receiving complaints from Indigenous families and loved ones and reviewing and assessing investigations of missing and/or murdered Indigenous women, girls, and 2SLGBTQQIA people.
- d. That the federal, provincial, and territorial governments establish an independent, Indigenous-led national task force to research into and make recommendations about how to improve the collection and sharing of information about missing and murdered Indigenous women, girls, and 2SLGBTQQIA people and, in particular, Métis and Inuit women, girls, and 2SLGBTQQIA people in Canada.
- e. That Indigenous policing be recognized as a component of self-government, and, wherever possible, Indigenous police forces be created and funded to provide policing to Indigenous communities.

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<sup>434</sup> “Reclaiming Power and Place,” Volume 1b, Annex 1, p. 254.

<sup>435</sup> “Reclaiming Power and Place,” Volume 1b, Annex 1, p. 246.

<sup>436</sup> “Reclaiming Power and Place,” Volume 1b, Annex 1, p. 259.

- f. That where possible, police forces designate Indigenous officers to either investigate or monitor the investigations of missing or murdered Indigenous women, girls, and 2SLGBTQIA people.

The Report also addressed healing and wellness. It described a number of programs and services which witnesses described as having contributed to the safety or healing of individuals, families and communities. These included services designed to provide housing for sexually exploited Indigenous women and youth, substance use counselling, mental health services, counselling for children who had witnessed abuse, sex worker support, Indigenous-focused child protection and family-support programs, and other forms of support for the families of missing and murdered Indigenous women, girls, and 2SLGBTQIAA people. The Inquiry noted the significant supportive role that families provided, including what they called “families of the heart”—close friends and community members who provide healing and safe spaces. The Inquiry also noted the healing role that participation in the Inquiry process itself played for many witnesses. Learning about traditional pathways to healing from Elders and participating in ceremonies was of particular importance. The Report explained that cultural safety and connection to identity are necessary components of healing.

Witnesses also described local efforts to commemorate victims as helping with healing and community building, including simple initiatives such as Facebook pages, pictures hung in community halls, and flowers. The Report also described larger-scale commemorative efforts such as the Survivors Totem Pole in Vancouver’s Downtown East Side (unceded Coast Salish territory). In a separate chapter focused on commemoration, the Report described its Legacy Archive, a collection of hundreds of artistic works created by Indigenous and non-Indigenous people that address Indigenous culture, justice, the commemoration of Indigenous girls, women, and 2SLGBTQIA people, or draw attention to violence against those people. Some of these works were donated by witnesses to commemorate their loved ones; others were the result of community collaborations. Many pieces in the archive reference the REDress Project, a public art installation created by artist Jaime Black to raise awareness about missing and murdered Indigenous women and girls.

Some witnesses identified efforts to give back to their communities, often by working with other vulnerable women, such as helping them to honour their loved ones and keep going. The need to heal future generations by working with Indigenous youth was also discussed. The Report noted that many Indigenous people do not have access to the services they need to heal and solve the crisis of violence, and that these services need to be provided on an indefinite basis. Many witnesses spoke about the need to heal men as a key component of combating violence. Some men, including former perpetrators of abuse, were witnesses. They talked about their own experiences of abuse and trauma during childhood and how they were able to begin healing and move away from violence.<sup>437</sup> This section of the Report concluded with this:

There were many important programs, initiatives, and outlets for grief shared within the context of the National Inquiry; in common, they included a foundation in a culturally safe, distinctions-based approach that allowed families to heal at their own pace. Together, they emphasize the importance of self-determined methods of healing appropriate for the community or family they engage.<sup>438</sup>

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<sup>437</sup> “Reclaiming Power and Place,” Volume, 1b, pp. 37–38.

<sup>438</sup> “Reclaiming Power and Place,” Volume 1b, p. 33.

The Report then described the Inquiry's approach to providing direct wellness and healing support to families, survivors, and other stakeholders over the course of the Inquiry's work. This program rested on four foundational directives for its work:

1. Reflect a holistic understanding of wellness that tends to all aspects of well-being, including emotional, physical, mental, spiritual, and social well-being;
2. Work within a trauma-informed approach that is woven into all aspects of practice;
3. Create culturally safe spaces respectful of identity, beliefs, and language; and
4. Incorporate both Indigenous and Western supports.<sup>439</sup>

In addition to its Truth-Gathering process, the Inquiry held four Guided Dialogues bringing together frontline service providers and community organizers to identify best practices and options for increasing the safety and protecting the rights of Indigenous girls, women, and 2SLGBTQQIA people. There was one Dialogue exploring the perspectives and best practices relating to each of the following groups: 2SLGBTQQIA, Inuit, Métis, and Quebec. Among the issues frequently raised by participants in these dialogues were the following:

1. Data collection and research;
2. Equitable representation within policy development, particularly for Inuit and Métis people;
3. Accountability, referring to the historical lack of implementation of past recommendations relating to Indigenous communities;
4. Wellness;
5. Coordinated services, referring to the predominantly siloed organization of social services;
6. Cultural safety;
7. Education; and
8. Continuity of care, referring to the importance of long-term, sustained relationships with service providers such as law enforcement and health care professionals.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

- (Call for Justice 1.1) We call upon federal, provincial, territorial, municipal, and Indigenous governments (hereinafter “all governments”), in partnership with Indigenous Peoples, to develop and implement a National Action Plan to address violence against Indigenous women, girls, and 2SLGBTQQIA people, as recommended in our “Interim Report” and in support of existing recommendations by other bodies of inquiry and other reports. As part of the National Action Plan, we call upon all governments to ensure that equitable access to basic rights such as employment, housing, education, safety, and health care is recognized as a fundamental means of protecting Indigenous and human rights, resourced and supported as rights-based programs founded on substantive equality. All programs must be no-barrier and must apply regardless of Status or location. Governments should:
  - i. Table and implement a National Action Plan that is flexible and distinctions-based, and that includes regionally specific plans with devoted funding and timetables for implementation that are rooted in the local cultures and communities of diverse Indigenous identities, with measurable goals and necessary resources dedicated to capacity-building, sustainability, and long-term solutions.

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<sup>439</sup> “Reclaiming Power and Place,” Volume 1b, p. 43.

- ii. Make publicly available on an annual basis reports of ongoing actions and developments in measurable goals related to the National Action Plan.
- (Call for Justice 1.8) We call upon all governments to create specific and long-term funding, available to Indigenous communities and organizations, to create, deliver, and disseminate prevention programs, education, and awareness campaigns designed for Indigenous communities and families related to violence prevention and combatting lateral violence. Core and sustainable funding, as opposed to program funding, must be provided to national and regional Indigenous women's and 2SLGBTQQIA people's organizations.
- (Call for Justice 1.9) We call upon all governments to develop laws, policies, and public education campaigns to challenge the acceptance and normalization of violence.
- (Call for Justice 3.5) We call upon all governments to establish culturally competent and responsive crisis response teams in all communities and regions, to meet the immediate needs of an Indigenous person, family, and/or community after a traumatic event (murder, accident, violent event, etc.), alongside ongoing support.
- (Call for Justice 5.2) We call upon the federal government to review and amend the Criminal Code to eliminate definitions of offences that minimize the culpability of the offender.
- (Call for Justice 5.3) We call upon the federal government to review and reform the law about sexualized violence and intimate partner violence, utilizing the perspectives of feminist and Indigenous women, girls, and 2SLGBTQQIA people.
- (Call for Justice 5.4) We call upon all governments to immediately and dramatically transform Indigenous policing from its current state as a mere delegation to an exercise in self-governance and self-determination over policing. To do this, the federal government's First Nations Policing Program must be replaced with a new legislative and funding framework, consistent with international and domestic policing best practices and standards, which must be developed by the federal, provincial, and territorial governments in partnership with Indigenous Peoples. This legislative and funding framework must, at a minimum, meet the following considerations:
  - i. Indigenous police services must be funded to a level that is equitable with all other non-Indigenous police services in this country. Substantive equality requires that more resources or funding be provided to close the gap in existing resources, and that required staffing, training, and equipment are in place to ensure that Indigenous police services are culturally appropriate and effective police services.
  - ii. There must be civilian oversight bodies with jurisdiction to audit Indigenous police services and to investigate claims of police misconduct, including incidents of rape and other sexual assaults, within those services. These oversight bodies must report publicly at least annually.
- (Call for Justice 5.5) We call upon all governments to fund the provision of policing services within Indigenous communities in northern and remote areas in a manner that ensures that those services meet the safety and justice needs of the communities and that the quality of policing services is equitable to that provided to non-Indigenous Canadians. This must include but is not limited to the following measures:
  - i. With the growing reliance on information management systems, particularly in the area of major and interjurisdictional criminal investigations, remote communities must be ensured access to reliable high-speed Internet as a right.

- ii. Major crime units and major case management must be more accessible to remote and northern communities on a faster basis than the service is being delivered now.
  - iii. Capacity must be developed in investigative tools and techniques for the investigation of sexualized violence, including but not limited to tools for the collection of physical evidence, such as sexual assault kits and specialized and trauma-informed questioning techniques.
  - iv. Crime-prevention funding and programming must reflect community needs.
- (Call for Justice 5.6) We call upon provincial and territorial governments to develop an enhanced, holistic, comprehensive approach for the provision of support to Indigenous victims of crime and families and friends of Indigenous murdered or missing persons. This includes but is not limited to the following measures:
    - i. Guaranteed access to financial support and meaningful and appropriate trauma care must be provided for victims of crime and traumatic incidents, regardless of whether they report directly to the police, if the perpetrator is charged, or if there is a conviction.
    - ii. Adequate and reliable culturally relevant and accessible victim services must be provided to family members and survivors of crime, and funding must be provided to Indigenous and community-led organizations that deliver victim services and healing supports.
    - iii. Legislated paid leave and disability benefits must be provided for victims of crime or traumatic events.
    - iv. Guaranteed access to independent legal services must be provided throughout court processes. As soon as an Indigenous woman, girl, or 2SLGBTQIA person decides to report an offence, before speaking to the police, they must have guaranteed access to legal counsel at no cost.
    - v. Victim services must be independent from prosecution services and police services.
  - (Call for Justice 5.7) We call upon federal and provincial governments to establish robust and well-funded Indigenous civilian police oversight bodies (or branches within established reputable civilian oversight bodies within a jurisdiction) in all jurisdictions, which must include representation of Indigenous women, girls, and 2SLGBTQIA people, inclusive of diverse Indigenous cultural backgrounds, with the power to:
    - i. Observe and oversee investigations in relation to police negligence or misconduct, including but not limited to rape and other sexual offences;
    - ii. Observe and oversee investigations of cases involving Indigenous Peoples;
    - iii. Publicly report on police progress in addressing findings and recommendations at least annually.
  - (Call for Justice 5.18) We call upon the federal government to consider violence against Indigenous women, girls, and 2SLGBTQIA people as an aggravating factor at sentencing and to amend the Criminal Code accordingly, with the passage and enactment of Bill S-215.
  - (Call for Justice 5.19) We call upon the federal government to include cases where there is a pattern of intimate partner violence and abuse as murder in the first degree under section 222 of the Criminal Code.
  - (Call for Justice 9.1) We call upon all police services and justice system actors to acknowledge that the historical and current relationship between Indigenous women, girls, and

2SLGBTQQIA people and the justice system has been largely defined by colonialism, racism, bias, discrimination, and fundamental cultural and societal differences. We further call upon all police services and justice system actors to acknowledge that, going forward, this relationship must be based on respect and understanding and must be led by and in partnerships with Indigenous women, girls, and 2SLGBTQQIA people.

- (Call for Justice 9.2) We call upon all actors in the justice system, including police services, to build respectful working relationships with Indigenous Peoples by knowing, understanding, and respecting the people they are serving. Initiatives and actions should include but are not limited to the following measures:
  - i. Review and revise all policies, practices, and procedures to ensure service delivery that is culturally appropriate and reflects no bias or racism toward Indigenous Peoples, including victims and survivors of violence;
  - ii. Establish engagement and partnerships with Indigenous Peoples, communities, and leadership, including women, Elders, youth, and 2SLGBTQQIA people from the respective territories and who are resident within a police service's jurisdiction;
  - iii. Ensure appropriate Indigenous representation, including Indigenous women, girls, and 2SLGBTQQIA people, on police services boards and oversight authorities;
  - iv. Undertake training and education of all staff and officers so that they understand and implement culturally appropriate and trauma-informed practices, especially when dealing with families of missing and murdered Indigenous women, girls, and 2SLGBTQQIA people.
- (Call to Justice 9.3) We call upon all governments to fund an increase in recruitment of Indigenous Peoples to all police services and for all police services to include representation of Indigenous women, girls, and 2SLGBTQQIA people, inclusive of diverse Indigenous cultural backgrounds, within their ranks. This includes measures such as the following:
  - i. Achieve representative First Nations, Inuit, and Métis diversity and gender diversity within all police services through intensive and specialized recruitment across Canada;
  - iii. Ensure that screening of recruits includes testing for racial, gender, gender identity, and sexual orientation bias;
  - v. In training recruits, include: history of police in the oppression and genocide of Indigenous Peoples; anti-racism and anti-bias training; and culture and language training. All training must be distinctions-based and relevant to the land and people being served; training must not be pan-Indigenous.
  - vii. End the practice of limited-duration posts in all police services and instead implement a policy regarding remote and rural communities focused on building and sustaining a relationship with the local community and cultures. This relationship must be led by and in partnership with the Indigenous Peoples living in those remote and rural communities.
- (Call to Justice 9.4) We call upon non-Indigenous police services to ensure they have the capacity and resources to serve and protect Indigenous women, girls, and 2SLGBTQQIA people. We further call upon all non-Indigenous police services to establish specialized Indigenous policing units within their services located in cities and regions with Indigenous populations.
  - i. Specialized Indigenous policing units are to be staffed with experienced and well-trained Indigenous investigators, who will be the primary investigative teams and

- officers overseeing the investigation of cases involving Indigenous women, girls, and 2SLGBTQQIA people.
- ii. Specialized Indigenous policing units are to lead the services' efforts in community liaison work, community relationship-building, and community crime-prevention programs within and for Indigenous communities.
  - iii. Specialized Indigenous policing units, within non-Indigenous police services, are to be funded adequately by governments.
- (Call for Justice 9.5) We call upon all police services for the standardization of protocols for policies and practices that ensure that all cases of missing and murdered Indigenous women, girls, and 2SLGBTQQIA people are thoroughly investigated. This includes the following measures:
    - i. Establish a communication protocol with Indigenous communities to inform them of policies, practices, and programs that make the communities safe;
    - ii. Improve communication between police and families of missing and murdered Indigenous women, girls, and 2SLGBTQQIA people from the first report, with regular and ongoing communication throughout the investigation;
    - iii. Improve coordination across government departments and between jurisdictions and Indigenous communities and police services;
    - iv. Recognize that the high turnover among officers assigned to a missing and murdered Indigenous woman's, girl's, or 2SLGBTQQIA person's file may negatively impact both progress on the investigation and relationships with family members; police services must have robust protocols to mitigate these impacts.
    - vii. Lead the provincial and territorial governments to establish a nationwide emergency number.
  - (Call for Justice 9.6) We call upon all police services to establish an independent special investigation unit for the investigation of incidents of failures to investigate, police misconduct, and all forms of discriminatory practices and mistreatment of Indigenous Peoples within their police service. This special investigation unit must be transparent in practice and report at least annually to Indigenous communities, leadership, and people in their jurisdiction.

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### **6.2.8. The Shadow Pandemic: Stopping Coercive and Controlling Behaviour in Intimate Relationships (Standing Committee on Justice and Human Rights, House of Commons, 2021)<sup>440</sup>**

This recent House of Commons committee report identified coercive and controlling behaviour as a pattern of conduct that removes a person's liberty and autonomy, including "physical, sexual, and emotional abuse, financial control, implicit or explicit threats to the partner or ex-partner, and against their children, belongings, or pets."<sup>441</sup> The Report concluded that coercive and controlling behaviour harms mostly women and children, can cause more harm than physical violence, costs

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<sup>440</sup> "The Shadow Pandemic: Stopping Coercive and Controlling Behaviour in Intimate Relationships—Report of the Standing Committee on Justice and Human Rights," House of Commons (April 2021), <https://www.ourcommons.ca/Content/Committee/432/JUST/Reports/RP11257780/justrp09/justrp09-e.pdf>.

<sup>441</sup> "The Shadow Pandemic," p. 6.

billions of dollars each year, is present in 95% of relationships where there is intimate partner violence, and has been exacerbated by the COVID-19 pandemic.

According to the Report, close to one of every three women in Canada experiences intimate partner violence, and 36% of intimate partner violence incidents and 5% of sexual assaults are reported to the police. Rates of intimate partner violence were estimated to have increased by 30% since the beginning of the COVID-19 pandemic, while pandemic-related restrictions made it more difficult for victims to seek help. The Report also referred to police service data suggesting that women in rural areas experience the highest rates of intimate partner violence in Canada. In spite of this, resources for women in these communities are particularly inadequate. The Report stated that a quarter of all calls to police are connected to intimate partner violence.

Coercive control is one of the strongest indicators of lethality, particularly when abusers have access to firearms; therefore, addressing coercive and controlling behaviour may prevent further serious violence. Because it is insidious, however, victims and their family and friends often do not recognize patterns of coercive controlling behaviour, nor do first responders. The Report reviewed the myriad other reasons victims do not report. These include the treatment of victims of gender-based violence by the justice system, the focus of the criminal law on physical incidents rather than patterns of behaviour, and the lack of effective tools for intervention. The lack of financial control that victims often experience also makes it difficult for them to leave.

The Report concluded that a paradigm shift in the justice system's approach to intimate partner violence is required. The Report reviewed the experience of other countries that have introduced criminal offences of coercive and controlling behaviour. It noted the disproportionate impact it would likely have on communities that are over-policed, noting that charges in the United Kingdom have predominantly been brought against Muslim men.

Witnesses were supportive of the agreement between ministers responsible for the status of women across the country to create a national action plan to end gender-based violence.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. That the House of Commons acknowledge the significant harms coercive and controlling behaviour causes in intimate partner relationships, recognize that these harms are not captured in criminal law at present, and further recognize that physical violence in intimate partner relationships is almost always preceded by a pattern of coercive and controlling behaviour.
2. That the Minister of Justice engage with his provincial and territorial counterparts to initiate a taskforce of experts with a mandate to review existing federal criminal legislation using a gender-based analysis plus other inclusive measures and make recommendations concerning the drafting of government legislation regarding a coercive and controlling behaviour offence in the Criminal Code, considering Bill C-247 as possible language for such an offence, and related measures to meet the needs of victims. This taskforce should report to the Minister within twelve months of formation.
3. That the House of Commons call on the federal government, the provinces, and the territories to implement measures to combat the challenges presented by the justice system for victims of coercive and controlling behaviour and intimate partner violence, in particular for women who are Indigenous, racialized, or living in poverty, with the clear objective of avoiding revictimization and unintended capture of victims in the charging process and further calls on the federal government to fund measures to support all victims

of coercive and controlling behaviour and intimate partner violence through court processes.

4. That the federal government consider increasing its funding for Canada's Strategy to Prevent and Address Gender-Based Violence to assist organizations working to support victims of coercive and controlling behaviour to deliver adequate levels of support services, such as counselling, housing, and other services aimed at helping victims in re-establishing their lives and ensure that culturally appropriate services are available and accessible.
5. That the federal government engage with provincial and territorial governments and other relevant stakeholders to promote and fund a public awareness campaign on coercive and controlling behaviour, as well as training of judicial system actors, such as police, lawyers, and judges, about the dynamics of such behaviour. Training must be trauma-informed, integrate intersectional perspectives, and be accompanied by tools and policies to support action on this issue.

### 6.3. Alberta

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#### 6.3.1. Public Fatality Inquiry into the Deaths of Blagica, Alex, and Josif Fekete (Alberta, 2005)<sup>442</sup>

On September 28, 2003 in Red Deer, Alberta, Josef Fekete shot and killed his ex-wife Blagica Fekete and their youngest child, Alex. He then killed himself. Ms. Fekete and Mr. Fekete had separated the previous year. They had an acrimonious custody dispute. During this dispute, Mr. Fekete repeatedly reported Ms. Fekete to the RCMP for failing to use a car seat for Alex, who was a toddler. Ms. Fekete reported to the RCMP that Mr. Fekete was harassing her and threatening to kill her and a friend of hers, Ms. Carr. Ms. Carr also reported these threats. The Red Deer RCMP officers who took these complaints dismissed Ms. Fekete's claims of threats and harassment, believing that she was trying to get the upper hand in the custody dispute. They also decided that Ms. Carr was not credible because she had met Ms. Fekete in the shelter, was a victim of domestic violence, and had a criminal record. No charges were ever laid against Mr. Fekete. The officers later admitted they had difficulty understanding much of what Ms. Fekete reported, as English was not her first language. The officers also ignored Ms. Fekete's statements that Mr. Fekete had firearms. On one occasion, the officer asked Mr. Fekete if he had unregistered firearms. Mr. Fekete said he had thrown them in the dump; he also offered to let the officer search his home. The officer did not conduct the search, assuming Mr. Fekete would not have made the offer if he indeed had guns in his home.

The public fatality inquiry into these deaths, conducted by Assistant Chief Judge David Plosz of the Provincial Court of Alberta, set out this chronology and inquired into the underlying causes. Officers who testified at the inquiry acknowledged that there was a lack of communication between constables, their supervisors, and their managers in the detachment; and there was no consistent information being passed on from watch to watch. They stated that it was challenging to keep the lines of communication open between the watches and between individual members. One officer told the inquiry that investigations were not being done to the proper RCMP standard during this period because of the large number of complaints and investigations the Red Deer

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<sup>442</sup> "Report to the Attorney General: Public Inquiry into the Deaths of Blagica, Alex, and Josif Fekete," Minister of Justice and Attorney General of Alberta (September 2005), <https://open.alberta.ca/publications/fatality-inquiry-2005-09-01#summary>.

Detachment was required to carry on. Detachment managers were struggling to find ways to manage the workload of the detachment and were aware that high-risk files were not being investigated properly.

The police records showed that the watch commanders were aware that the members were not treating domestic violence files properly, including improper documentation, a reliance on emergency protection orders rather than laying substantive charges, and closing files because the victim did not want to lay charges without ensuring the victim was properly supported to make that decision. They had also been assuming that the Crown would screen out charges as having no reasonable likelihood of conviction and had not considered bringing all the complaints made by Ms. Fekete to the Crown to determine if there was sufficient evidence to prefer charges against Mr. Fekete. They acknowledge in hindsight that this would have been a good course of action.

Associate Chief Judge Plosz noted that following the killings, the detachment created a domestic violence unit with two specially trained constables, who were responsible for investigating all domestic violence complaints. These investigators were to look at the history and root causes of the incidents and would encourage complainants to follow through with prosecution. Although the RCMP had not had a category of officers specializing in domestic violence, this initiative of the Red Deer detachment had led the national office to create one. This unit had improved communication with the child protection agency and participated in joint training programs with that agency, shelter staff, and other Red Deer agencies. “K” Division headquarters had also conducted reviews of the administration and management of the Red Deer Detachment. That review led to recommendations for improvements to the quality of investigations, supervision, training, and communication, both internally and with external agencies.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 2) All officers in charge, watch commanders, and all other senior ranking officers in a supervisory capacity of all police forces in Alberta, particularly the RCMP and most particularly the Red Deer RCMP Detachment, ensure that all of their members be aware of and are compliant with all instructions, directives, and policies issued by their own police force, particularly relating to domestic violence complaints and investigations.
2. (Recommendation 5) All police officers, when receiving complaints or statements made by people whose first language is not English, realize that such people may not be able to express themselves in English as clearly and succinctly as those with English as their first language. Therefore, officers should make whatever effort is necessary to ensure that the complaint or statement made is an accurate reflection of what that person is trying to convey. On occasion this may require the assistance of an interpreter.
3. (Recommendation 6) Police officers should not treat chronic complaints made by a recipient of domestic violence, such as those made by Blagica Fekete regarding death threats, as a nuisance and therefore unworthy of belief and thus not conducting further investigation, which could result in arrest and laying of charges.
4. (Recommendation 7) Police officers should not summarily discredit or be dismissive of the veracity of a potential witness, as was done with Valerie Carr, who could possibly provide corroboration to a domestic violence complaint.
5. (Recommendation 8) Police officers should, before concluding that corroboration of a domestic violence complaint was necessary before a charge should be laid against the alleged perpetrator, first inquire from the complainant if anyone else was present when the incident occurred who could provide corroborating evidence, as this is basic police work. For example,

in Blagica Fekete's case, a number of Red Deer City RCMP officers, including supervisory officers, took the position that corroboration was required before laying a charge against Josef Fekete, without inquiring if anyone was present who could provide such corroboration, since in many situations when threats are uttered, no one else is present except the person uttering the threats and the recipient.

6. (Recommendation 9) In cases such as the Feketes, where numerous allegations are made by each party against the other, police officers should focus more on the serious allegations, such as those made by Blagica Fekete, rather than on the minor ones, such as those made by Josef Fekete, which didn't involve violence or threats of violence against him.
7. (Recommendation 12) Police officers should give serious consideration to apply for a firearms prohibition order under Section 111 of the Criminal Code in domestic violence cases such as the Fekete case, where the police were advised on numerous occasions that Josef Fekete possessed firearms, since seizure of firearms, while obviously desirable prior to such an application, is not a mandatory prerequisite before commencing it.
8. (Recommendation 13) Wherever possible, all police forces and RCMP detachments have certain members designated as domestic violence investigators, so that all such cases and complaints are brought to their attention for compilation and determination of action to be taken, in order to provide continuity and a historical perspective.
9. (Recommendation 14) The Red Deer Detachment continue its liaison and teamwork with the Department of Children's Services and the Central Alberta Women's Shelter regarding domestic violence cases.
10. The RCMP, as well as all other police forces in Alberta, should not treat Emergency Protection Orders as a civil matter and therefore not part of their responsibility but should assist victims of domestic violence in making applications for such an order. Presumably, that is one of the functions of their victim services unit.
11. In domestic violence files, particularly chronic ones such as the Feketes, the police investigators present the entire chronology of complaints and investigations to the Chief Crown Prosecutor or her or his designate, to determine whether there is sufficient evidence to lay a charge or charges and proceed to arrest and prosecution. This type of interaction between the Crown Office and the Police should be encouraged.

## 6.4. British Columbia

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### 6.4.1. Coroner's Inquests into the Deaths of the Gakhal Family (the "Vernon Inquest") (British Columbia, 1996)<sup>443</sup>

On April 5, 1996, Mark Chahal shot and killed his estranged wife, Rajwar Kaur Chahal (Gakhal), and eight members of her family before committing suicide. They were Karnail Singh Gakhal (father), Darshan Kaur Gakhal (mother), Balwinder Kaur Gakhal (sister), Khalwinder Kaur Gakhal (sister), Halvinder Kaur Gakhal (sister), Jaspal Singh Gakhal (brother), Jasbir Kaur Saran (sister),

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<sup>443</sup> "Coroner's Inquests into the Deaths of Rajwar Kaur Gakhal, Karnail Singh Gakhal, Darshan Kaur Gakhal, Balwinder Kaur Gakhal, Kalwinder Kaur Gakhal, Halvinder Kaur Gakhal, Jaspal Singh Gakhal, Jasbir Kaur Saran, and Baljit (Roger) Singh Saran" (the "Vernon Inquest"), Ministry of the Attorney General of British Columbia (26 September 1996).

and Baljit (Roger) Saran (brother-in-law). This was one of the worst mass casualty incidents in Canadian history and led to several inquests and reviews (see section 6.4.2. below), including a coroner's inquest. Although inquest juries do not typically make findings of fact, the coroner summarized the circumstances revealed by the inquest evidence relevant to the jury's recommendations.

Mark Chahal and Rajwar Gakhal were married in April 1994 as a result of an arranged marriage. Their marital home was in Burnaby, BC. They both came into the marriage with substantial financial assets. Upon marriage, Mr. Chahal became the manager of their financial assets. The marriage lasted less than nine months. Ms. Gakhal's family members confronted Mr. Chahal about his abuse in December 1994. Ms. Gakhal moved out of the home within a week. Mr. Chahal claimed she took more of the financial assets than she was entitled to. In early January 1995, Ms. Gakhal reported Mr. Chahal's conduct during the marriage to the police in Vernon, BC (where her family home was). She reported that he threw objects at her, choked her, kicked her, pulled her across the floor, and threatened to kill her if she told anyone. She also reported that he was jealous, controlled her movements and became upset if she paid any attention other men. She stated that she did not want the police to take action and that she was not concerned for her safety because she was living in Vernon while Mr. Chahal was living in Burnaby.

The divorce proceedings continued through 1995. Ms. Gakhal sought counselling and support from various community resources. Mr. Chahal received counselling on two occasions in February 1995. In early March 1995, Ms. Gakhal again reported Mr. Chahal to the Vernon RCMP for nuisance phone calls. The RCMP contacted Mr. Chahal and warned him to stop making the phone calls. He denied that he was responsible; however, the calls stopped after the request. That same month, Mr. Chahal applied for a firearm permit through the RCMP Burnaby detachment. At the time of the purchase, the Police Information Retrieval System (PIRS) indicated that he was a spousal abuse suspect in a Vernon RCMP file. The permit was approved, and he bought a semi-automatic handgun. Mr. Chahal acquired a second handgun in June 1995.

In late January 1996, Ms. Gakhal spoke to Constable Weatherall at Vernon RCMP, who was in charge of Ms. Gakhal's file. She complained about Mr. Chahal's conduct during parts of the divorce proceedings. She said she would bring in a written statement once she completed it. On February 16, 1996, Ms. Gakhal's sister, Jasbir Saran, reported Mr. Chahal to the Abbotsford Police Department. She alleged that he had made death threats against her multiple times. This report was not brought to the attention of RCMP in Vernon. That same month, Ms. Gakhal provided her written statement to the police. In it, she said Mr. Chahal had threatened her and her family members and that she was very concerned for her safety and that of her family. She referenced her sister's report to the Abbotsford RCMP. However, this statement was never brought to the attention of Constable Weatherall. At the inquest, Constable Weatherall said that had she been aware of this statement and of Ms. Saran's report, she would have acted on them.

On March 27, 1996, Mr. Chahal purchased a ten-round magazine clip for one of his handguns. He practiced shooting at his gun club several days later. He rented a car on April 4, 1996, drove to Vernon, and checked into a hotel. The next morning, Ms. Gakhal and her family were at home. Mr. Chahal murdered them and then returned to his hotel room and committed suicide.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. That the Attorney General's policy, definition, and guidelines "Violence Against Women in Relationships" include threats against extended family members as reasonable grounds to proceed on this policy decision tree.

2. That a full investigation of all alleged abuse/threats include direct contact with victim and perpetrator and follow-up with family members and other possible witnesses, regardless of the wishes of the complainant.
3. That training for police and justice system workers relating to violence against women in relationships reinforce that extended family are important when compiling information.
4. That policy clarify that the K-file designation (violence against women in relationships) be assigned immediately on the opening of the file.
5. That concurrent or subsequent complaints from any jurisdiction be coordinated and cross-referenced through CPIC and PIRS. The K-designation should be noted on the PIRS system and CPIC system and be in the same location on each type of screen and on related paper documentation.
6. That Officers document the date and results each time a PIRS and CPIC review is done.
7. All municipal police detachments must keep PIRS up to date with respect to all files and gun acquisitions.
8. Develop a risk assessment tool to help frontline police and victim assistance workers to evaluate and/or screen persons who may either be predisposed to violence or have the potential to harm spouses or family members.
9. That a one-file system on all complaints involving Violence in Relationships be done. Copies of all related complaints made in other police agencies be kept on file at the detachment closest to the complainant.
10. That all complaints involving the same complainant and suspect, if violence in a relationship is involved in any of the complaints, should be assigned to the same investigating member.
11. Complaints involving the same suspect and extended family members of the original complainant be assigned to this master file and investigating member.
12. That there be education for police officers regarding violence in relationships, the cycle of violence, and risk factors after relationship breakdown, in consultation with community agencies.
13. That the above agencies continue working towards an integrated and cooperative model in relation to Violence Against Women in Relationships and that funding adequately address the training and resource requirements to accomplish that.
14. That the above agencies collaborate to *improve* public education about the risk factors during a relationship breakdown and subsequent separation.<sup>444</sup>
15. To increase the awareness of what is presently available in the community and how to access these resources (i.e., counselling, crisis lines, 1-800 numbers) through public notices (e.g., TV ads).
16. That the above agencies explore intervention opportunities at the complaint level so that counselling may be offered at an earlier opportunity, especially to abusers.
17. Ensure that Victim Services/Assistance and other government referral programs set a standard of minimum qualifications for counsellors and volunteers.
18. That provincial policy be developed for verbal and written information intake and documentation handling. Where such policy already exists; police officers, frontline clerical

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<sup>444</sup> Emphasis in original.

staff, and filing clerks should receive refresher training to ensure these policies are adhered to.

19. Ensure that staff involved in PIRS and CPIC checks on Firearms Acquisition Certificates (FAC) and permits are *adequately* trained.<sup>445</sup>
20. That professional publications arising out of the above agencies include material to assist the various professions in identifying possible interventions for clients who may be involved in relationship breakdowns and aware of spousal assault or threats within that relationship, and provide any other useful educational information.
21. An independent auditor through the Attorney General's office to randomly assess police detachments' interpretation of the Violence Against Women policy and advise and/or assist as necessary for further education or improvements. Findings should be related to all police agencies without disclosing particulars of any detachments to maintain anonymity.
22. That CPIC provide a database for firearms registrations, peace bonds, restraining orders, and domestic violence files; or create some other Canada-wide registry (i.e., special interest persons).

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#### **6.4.2. Amendments to "E" Division RCMP Operational Policies Pertaining to Relationship Violence and the Processing of Firearms Applications (RCMP, 1998)<sup>446</sup>**

Five months before Mark Chahal committed the mass murder in Vernon (summarized above in section 6.4.1.), a man named Larry Scott shot his ex-girlfriend, Sharon Vesilek, also in Vernon, BC. Ms. Vesilek survived the shooting. She had ended her relationship with Mr. Scott because he was too controlling. He then stalked and harassed her, putting sugar in her gas tank, following her, and scratching her car. She reported him several times to the Vernon RCMP and made them aware that he owned a shotgun. Six weeks after she broke up with Mr. Scott, he shot her in the arm and back. She pretended she was dead, and he killed himself. Ms. Vesilek survived.<sup>447</sup>

The RCMP then commissioned Justice Josiah Wood of the BC Court of Appeals to conduct independent reviews of the RCMP responses to and investigations of the complaints from Ms. Vesilek as well as Ms. Gakhal (Mr. Chahal's ex-wife) prior to the two shootings.<sup>448</sup> His reviews focused on whether the RCMP followed their policies regarding relationship violence, criminal harassment and stalking, and firearms permits. Judge Wood issued his reports in early 1997. He found deficiencies in the investigations and in the policies themselves. Judge Wood issued a third report, in which he reviewed the "E" Division's operational policies on relationship violence and the processing of firearms permits, as well as training programs on these topics. Judge Wood made findings about both incidents in these three reports, including the following:<sup>449</sup>

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<sup>445</sup> Emphasis in original.

<sup>446</sup> "Recommendations for Amendments to "E" Division RCMP Operational Policies Pertaining to Relationship Violence and the Processing of Firearms Applications" by J. Woods for the Royal Canadian Mounted Police (1998).

<sup>447</sup> See "She Lived to Change the System," *The Province* (30 Nov 2006), <https://www.pressreader.com/canada/the-province/20061130/281977488128677>.

<sup>448</sup> The reports from the reviews are not available online and have been requested from the federal Department of Justice as of this writing. The findings are summarized in Judge Woods' third report, "Recommendations for Amendments to 'E' Division RCMP Operational Policies."

<sup>449</sup> Some of these findings mirror the facts summarized by the coroner following the Vernon Inquest but are repeated here to provide context for Judge Wood's commentary and recommendations.

- i. Two weeks after their separation, Ms. Gahkal reported to an RCMP detachment<sup>450</sup> that during her marriage, Mr. Chahal had repeatedly assaulted and threatened her at their residence in Burnaby. She told the investigating officer that there were no witnesses or injuries, and she had never sought medical attention. She did not tell the police that he had threatened to kill her. She refused to provide a formal written statement and asked that the police not investigate her report, not contact Mr. Chahal, and not charge him.
- ii. Three days later, on January 9, 1995, Ms. Gahkal filed a petition for divorce in the BC Supreme Court. In her petition, she made seventeen specific allegations of assaults and threats, including death threats and threats to obtain a handgun, against Mr. Chahal. She had not referred to those specific incidents in her report to the RCMP.
- iii. In February and June 1995, Mr. Chahal applied for registration certificates for a semi-automatic handgun and a revolver. He received the certificates, as well as permits to transport and carry the weapons between March and June 1995.
- iv. In April 1995, Ms. Gahkal reported that Mr. Chahal was making harassing telephone calls. The investigating officer spoke to Mr. Chahal, who denied making these calls. That officer tried to persuade Ms. Gahkal to support a criminal investigation and charges against Mr. Chahal in relation to the abuse she had reported in January 1995.
- v. In January 1996, Ms. Gahkal showed detailed notes relating much of the information included in her divorce petition to the investigating officer, Constable Weatherall. She did not allow Constable Weatherall to copy the notes. She later added to the notes and delivered them to the detachment, but Constable Weatherall was never informed of this. The following month, February 1996, Ms. Gahkal's sister told the Abbotsford RCMP that Mr. Chahal had made death threats to her over the phone. This information did not appear to have been forwarded to the Vernon detachment. There were no further reports to police prior to the April 1996 murders.
- vi. In his report regarding the attempted murder of Sharon Vesilek, Judge Wood found that Mr. Scott had acquired a FAC in 1980, which expired in 1985. He owned various long-barrelled shotguns and rifles. Mr. Scott and Ms. Vesilek were in a relationship for seventeen months, during which time there was no violence. After Ms. Vesilek ended the relationship, Mr. Scott engaged in a persistent pattern of harassment. He made nuisance calls, followed Ms. Vesilek in her car, came to her workplace, and likely vandalized her car three times. Ms. Vesilek contacted the RCMP at least fourteen times to complain about these incidents or inquire as to the progress of the investigation. She provided detailed chronologies of the incidents, but officers conducted virtually no investigation. They considered her complaints to be isolated reports of property damage and nuisance calls.
- vii. In November 1995, Mr. Scott shot Ms. Vesilek twice with a sawed-off shotgun. She pretended to be dead, and Mr. Scott killed himself. She survived, with permanent physical injuries.
- viii. Judge Wood found that the officers who investigated Ms. Gahkal's complaints "generally complied" with the 1993 RCMP national and "E" Division policies on relationship violence and the BC Attorney General's 1993 policy entitled "Violence Against Women in Relationships" (VAWIR). Judge Wood noted that he made the

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<sup>450</sup> The version of the report that the federal government provided to the Mass Casualty Commission has the name of the detachments redacted.

- finding of “general compliance” in part because the policies on relationship violence contemplated complaints of recent violence rather than complaints of past violence. There were no directions in these policies as to steps to be taken when a complainant reported historical violence and/or asked that no formal investigation be conducted.
- ix. Judge Wood also found that there was general compliance with the policies on firearms certificates and permits. Investigators did fail to record certain steps in the investigation file, and the failure to provide Ms. Gahkal’s notes to the investigating officer was a breach of document-handling policies. Mr. Chahal’s applications to register his firearms were not properly completed, and some information that should have been included was not forwarded to the Commissioner as required by the National Firearms Manual.
  - x. With respect to Ms. Vesilek’s complaints, Judge Wood found that “there was virtually no compliance with the various provisions of the applicable RCMP policies or with the VAWIR policy.”<sup>451</sup> He noted that the investigating officers failed to record many of the incidents and did not engage in any investigation of Ms. Vesilek’s complaints.

Judge Wood noted that the murders of the Gakhal family and attempted murder of Ms. Vesilek illustrated “two very real difficulties the RCMP, and police forces generally, have in providing an effective response” to violence against women.<sup>452</sup> The first is the difficulty in responding to complaints of past violence when there is no physical evidence and a request from the complainant that the complaint be kept confidential. The second is some officers’ outdated attitudes about complaints of relationship violence, particularly criminal harassment.

After reviewing the officers’ compliance with existing RCMP “E” Division policies, Judge Wood reviewed the policies themselves. He identified several deficiencies, including:

- i. The Division’s “Violence in Relationships” (VIR) policy contemplates recent or ongoing violence only. It does not provide guidance for the officers’ use of discretion when the complaint does not require an immediate police response, made by a victim who is unable to cooperate with an investigation. This gap required officers in that situation to interpret and apply the relevant policies to circumstances for which they were not intended. That interpretation would be guided by “the police officer’s experience, education, training and judgment and by the degree of supervision available at the time investigative decisions have to be made.”<sup>453</sup>
- ii. There was no significant policy on the investigation of criminal harassment.
- iii. There was a widespread practice of designating complaints as “for information only” complaints, where officers determined that no further investigation would be undertaken, either because the complainant requested that the information be kept confidential or because the officer determined that an investigation would not result in a charge or a conviction. There was no policy permitting such designation. Three complaints by Ms. Vesilek to the RCMP had been designated this way.
- iv. The policy on screening FAC and other firearms permits was not sufficient to ensure that only suitable applicants obtained these permits.

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<sup>451</sup> “Recommendations for Amendments to ‘E’ Division RCMP Operational Policies,” p. 8.

<sup>452</sup> “Recommendations for Amendments to ‘E’ Division RCMP Operational Policies,” p. 9.

<sup>453</sup> “Recommendations for Amendments to ‘E’ Division RCMP Operational Policies,” p. 13.

Judge Wood emphasized that a “complete investigation” as required by various policies and particularly in intimate partner violence cases requires a detailed written statement from the victim as well as interviewing the suspect with the goal of obtaining a statement. However, he noted:

It is a notorious fact that many women who are victims of violence in a relationship find it impossible either to complain to the police when they are abused or to cooperate with a subsequent criminal investigation when that abuse finally comes to the attention of the police. All of the available research on the subject confirms that there are a host of complex reasons for this phenomena, many if not most of which are related to the power imbalance that characterizes abusive relationships and leaves the woman victim convinced that she must suffer in silence. Such victims frequently feel shame or guilt and blame themselves for what they perceive to be their failure in making the relationship a success. Many mistakenly believe that the abuse will stop, if only they try harder and become more compliant. All of these and many more complicating factors explain why the average woman in a violent relationship will suffer abuse as many as 35 times before making her first complaint to the police.<sup>454</sup>

This also explains why women often request that their reports of abuse be kept confidential and ask for no investigation to be conducted. Judge Wood noted that it often takes considerable time, counselling, and support before a woman in these circumstances will take the next step of participating in a formal investigation. Moreover, many women fear further violence should the abuser learn that they have spoken with the police.

On the other hand, giving officers the discretion not to conduct a complete investigation (including speaking with the accused) may lead busy officers to exercise that discretion too often. As well, violence in relationships often increases over time, and some argue that taking a complaint about such violence “for information only” cannot be justified given these dynamics. Another argument Judge Wood considered was the suggestion that no matter how carefully the discretion not to proceed with a complete investigation is exercised, there are bound to be tragedies, given how unpredictable relationship violence can be. The officers who exercise their discretion with tragic results will be held accountable, unfairly, for such tragedies. Judge Wood stated the following:

Although the RCMP commissioned this Report as a direct result of [the two tragedies] there is a danger associated with recommending policy changes in response to the occurrence of such terrible events. For example, although one could recommend policy changes which would have the effect of entirely removing any independent decision-making ability or discretion on the part of an officer investigating a complaint of relationship violence, including criminal harassment, or the suitability of a person to acquire a Firearms Acquisition Certificate (“FAC”), any decision to do so would be an unfortunate and misguided over-reaction. It is not possible to create policy in response to a particular incident that will ensure that a similar incident will not ever occur again. As the [Gakhāl] tragedy illustrates, there is a level of madness against which no amount of policy will ever be effective.<sup>455</sup>

Judge Wood concluded that officers should have discretion not to conduct a complete investigation and to keep the complaint confidential only in very narrow circumstances, when:

- a. The complainant states that she will not cooperate with an investigation or prosecution;
- b. There is no evidence supporting a charge other than that of the complainant; and

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<sup>454</sup> “Recommendations for Amendments to ‘E’ Division RCMP Operational Policies,” p. 15.

<sup>455</sup> “Recommendations for Amendments to ‘E’ Division RCMP Operational Policies,” p. 2.

- c. The complainant asks that the suspect not be notified of her complaint because she fears he will retaliate with violence.

The officer must first attempt to persuade the complainant to cooperate, stress the potential danger the violence poses to the complainant and to her immediate and extended family, and advise the complainant that the police will not be able to take steps to protect her. The officer must also attempt to obtain the complainant's consent to refer her to a community-based victims' services agency where she could obtain support, counselling, and sanctuary, if necessary.

Judge Wood concluded that even after all these conditions are met, the officer should not be permitted to exercise this discretion if there are reasonable grounds to believe that the risk to the victim is unacceptably high, whether or not the suspect learns of her complaint. When there is evidence that the suspect possesses firearms or other offensive weapons, the officer "can and must" reduce the level of risk to the victims by taking steps to search for and seize such weapons.<sup>456</sup> Judge Wood noted that a warrant to do so can be obtained on the basis of the officer's reasonable belief that it is not desirable in the interests of the safety of the victim that the suspect possess any firearms or other offensive weapons;<sup>457</sup> the cooperation of the victim is not necessary.

Judge Wood also concluded that the discretion permits officers only to conclude the investigation without speaking to the suspect or anyone else who may notify the suspect of the investigation; the investigation should continue in all other respects, such as database searches. The officer should make all reasonable efforts to obtain other independent evidence of the offence. The file must be kept open for at least eighteen months and reviewed from time to time, with discrete inquiries of the complainant to determine whether she is ready to cooperate with an investigation. As well, if other independent evidence comes to light allowing for a charge, the officer should then conduct a complete investigation.

Rather than creating an inflexible policy covering all aspects of a police investigation, Judge Wood designed his recommendations to provide training and guidance to investigating officers and their supervisors regarding the dynamics of relationship violence, which would in turn allow them to exercise properly their discretion during investigations or FAC application determinations.

Judge Wood also noted that the separation of the policy on stalking from other violence in relationships policies in the Division may have the effect of narrowing officers' understanding of the range of conduct involved in violence in relationships. The officers investigating Ms. Vesilek's complaints failed to recognize that the acts of harassment she reported were committed in the context of a relationship that had recently ended and failed to investigate in accordance with stricter requirements of the Division's VIR policy or the provincial VAWIR policies. Judge Wood noted that although criminal harassment may arise in apparently nonviolent relationships, "to the

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<sup>456</sup> "Recommendations for Amendments to 'E' Division RCMP Operational Policies," p. 21.

<sup>457</sup> This warrant would be obtained under s. 103(1) of the Criminal Code (now s. 117.04(1)), which provides:

Where, pursuant to an application made by a peace officer with respect to any person, a justice is satisfied by information on oath that there are reasonable grounds to believe that the person possesses a weapon, a prohibited device, ammunition, prohibited ammunition or an explosive substance in a building, receptacle or place and that it is not desirable in the interests of the safety of the person, or of any other person, for the person to possess the weapon, prohibited device, ammunition, prohibited ammunition or explosive substance, the justice may issue a warrant authorizing a peace officer to search the building, receptacle or place and seize any such thing, and any authorization, licence or registration certificate relating to any such thing, that is held by or in the possession of the person.

extent that it is a manifestation of control and intimidation, criminal harassment is indistinguishable from any other form of relationship violence and should be recognize as such” in the relevant policies, to provide proper guidance to investigators and to and ensure proper investigation of these complaints.<sup>458</sup> The policy on criminal harassment should also inform investigating officers that this conduct is often part of an overall pattern and should not be viewed as isolated events. Officers should also be made aware that victims are often reluctant to report due to self-blame, shame, guilt, or a belief that without property damage, physical harm, or direct threats, there is no point in calling police. Victims may also underestimate the risk such conduct poses. Officers should also assume for the purposes of the investigation that prior unexplained acts of vandalism were committed by the suspect.

Judge Wood also commented on the difficulties resulting from the existence of two different policies governing police responses to complaints involving relationship violence. He noted that the provincial VAWIR policy was separated from the Division VIR policy and at times inconsistent with it, particularly with respect to the discretion available to officers during the course of an investigation. The VAWIR policy was referred to in the Division VIR policy as a “guideline,” which caused investigators to believe that compliance with it was not necessary. The version of the VAWIR policy appended to the Division VIR policy was also out of date. The Division VIR policy did not contain any information on the cycle or continuum of violence in abusive relationships. The VAWIR policy, on the other hand, made specific reference to a continuum of violence from harassing calls to aggravated assault. Its definition of the term “violence against women in relationships” also stated that behaviour “such as intimidation, mental or emotional abuse, sexual abuse, neglect, deprivation and financial exploitation, must be recognized as part of the continuum of violence against young and elderly women alike.” Judge Wood recommended similar changes to the VIR. He also recommended that the policy make specific reference to the danger extended family members may face where there is a violent relationship and to consider whether they may be at risk.

Because not all investigating officers would be aware that relationship violence might be directed to extended family members, Judge Wood recommended expanding the interview protocol in the VAWIR and the VIR policy to include taking statements from extended family members, if they may have any relevant background information or evidence that could assist in the investigation. Judge Wood also recommended changes to the language in the VIR policy to make it more reflective of the pro-charge directive in the province’s VAWIR, by incorporating the specific language in the VAWIR. That language includes the following: “A pro-active charge policy is based on the assumption that police will conduct a complete investigation in every case, including those cases that do not immediately appear likely to proceed to prosecution.”

The Division VIR policy and VAWIR policy did not require officers investigating complaints of relationship violence to search CPIC or other databases for information about the suspect. Judge Wood noted that particularly where the complainant is reluctant and there is no recent violence, such background information is necessary for a proper risk assessment. It can also assist the officer in determining whether the suspect has access to a weapon. Judge Wood noted that the VIR policy directs officers to determine, in every complaint of relationship violence, whether the accused has access to a firearm, and to seize the weapon or weapons if there are grounds to do so under the relevant provisions of the Criminal Code. However, those grounds are not set out in the policy. He recommended the policy be amended to provide specific information regarding

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<sup>458</sup> “Recommendations for Amendments to ‘E’ Division RCMP Operational Policies,” p. 26.

those grounds. Judge Wood declined to recommend that officers conduct searches for weapons or seek prohibition orders in every investigation of relationship violence.

Judge Wood also reviewed the adequacy of the RCMP's training programs on relationship violence and firearms permits. He noted that because he was not an educator nor an expert in matters of law enforcement, he could not critique the quality of existing course content or design curricula or methods of instruction for courses he recommended. Because of the logistical problems associated with providing training to thousands of officers and supervisors spread across a large province, he recommended the creation of a task force in "E" Division. This task force would be comprised of RCMP personnel, Ministry staff, and civilian professionals with skills in the design and delivery of the kind of programs he recommended.

Judge Wood engaged in a detailed review of the programs available to cadets and officers at the time that related to relationship violence, criminal harassment, and firearms. He noted that although the cadet programming in force in 1996 contained significant components related to relationship violence and criminal harassment, older officers would have had only rudimentary training on relationship violence and almost no training on criminal harassment. He noted that both of the officers who investigated Ms. Vesilek's complaints of harassment had been in service for more than twenty years. There were training courses that contained adequate content on relationship violence and criminal harassment, but those courses did not have the capacity to train the thousands of officers in a reasonable timeframe. Moreover, none of the RCMP programs available at the time of Judge Wood's report addressed historical complaints where the complainant is unable to cooperate with an investigation or prosecution.

Judge Wood noted that a report in 1995 had identified an urgent need for police training on criminal harassment in British Columbia, yet the situation had not improved. He recommended that training on criminal harassment and on relationship violence be made available to all general duty, General Investigations Section, and supervisory members of "E" Division within 24 months. He stated:

I recognize that such a massive training exercise will be extremely expensive and difficult to organize. But the alternative is unacceptable. To continue to limit much needed training by only making it available on an infrequent basis to eight or nine officers at a time is to guarantee that there will be more tragedies such as those which occurred in the Chahal and Vesilek incidents.<sup>459</sup>

Judge Wood also made several recommendations relating to firearms applications, which are not set out here.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. "E" Division VIR policy to be amended to include specific policy relating to complaints of historical instances of abuse reported by uncooperative complainants.

Division VIR Policy be amended to stipulate that investigating officers have a narrow discretion to accept a complaint of relationship violence on a confidential basis in cases where the following conditions exist:

- i. There is no evidence of the alleged offence other than the victim's complaint;

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<sup>459</sup> "Recommendations for Amendments to 'E' Division RCMP Operational Policies," p. 104.

- ii. There is a reasonable basis for believing that the risk to the victim would be increased by confronting the suspect with the fact that she has complained;
  - iii. There [is] no evidence that the suspect has firearms;
  - iv. The suspect is unaware that the victim has made a complaint to the police;
  - v. The complainant requests that her complaint be kept confidential and that no investigation be conducted as she is fearful that if the suspect is contacted by the police he will further victimize her;
  - vi. The victim has refused to cooperate with any investigation and attempts to persuade her to cooperate have been unsuccessful; and
  - vii. The officer fully documents in the investigational file the information provided from the complainant, including the reasons for her request for confidentiality and the information provided to the complainant.
2. Division VIR Policy be amended to stipulate that in such cases, the investigating officer may refrain from conducting a complete investigation only to the extent of not contacting or interviewing the suspect or anyone likely to inform the suspect that a complaint has been made. All other components of a complete investigation, as outlined in this Report, must be completed. The suspended investigation steps are to be completed notwithstanding the decision to accept the complaint on a confidential basis, either upon notification that the complainant wishes to support the investigation or upon the receipt of any evidence upon which a RTCC can be forwarded with a recommendation to charge. In the latter case, the complainant must be notified in advance that a full investigation is to proceed.
  3. Division VIR Policy be amended to require investigating officers to inform victims that the decision about whether a charge proceeds is not her decision.
  4. Division VIR Policy be amended to require that in any case where there is a decision not to conduct a complete investigation, the investigative file must not be concluded for a period of at least 18 months, during which the investigating officer is required to follow up with efforts to persuade the complainant to cooperate with the investigation.
  5. The Violence in Relationships Check Sheet be amended to reflect the mandatory obligation on an investigating officer to attempt to persuade a reluctant complainant to cooperate with the investigation and prosecution or to attempt to obtain her consent to a referral to an appropriate community-based victims services agency.
  6. "E" Division Policy for the investigation of all forms of relationship violence to be consolidated into a single comprehensive policy statement.
  7. Division VIR Policy be amended to specify that it is applicable to the investigation of any offence that occurs in the context of an ongoing or former relationship between the victim and the suspect. A "relationship" in this context includes one existing only in the mind of the suspect.
  8. Division VIR Policy be amended to include all "E" Division policy relating to the offence of criminal harassment, including a description of the critical elements of that offence, the range of conduct that can constitute such an offence, and the specific factors that should be considered during an investigation into that form of relationship violence.
  9. Division VIR Policy be amended to include a description of the dynamics of the continuum of violence and a description of conduct characteristics of violent or abusive relationships, including conduct amounting to criminal harassment.
  10. Division VIR Policy be amended to make specific reference to the danger that relationship violence poses to extended family members.

11. Division VIR Policy be amended to incorporate the following portion of paragraph 28 of the Amended VAWIR Policy:

The police officer will inform the victim of any community-based specialized victim services (including women assault centres), and will refer her case with her permission. Where a specialized program does not exist, permission to refer her case to a Crown-based victim service should be sought.

12. Division VIR Policy be amended to provide that extended family members be identified as possible victims or witnesses in relationship violence complaints and to provide that these individuals be formally interviewed, where it is determined that they have information relevant either to the background of the complaint or the contemporary circumstances of the alleged abuse.
13. Division VIR Policy be amended by deleting the provisions currently in Chapter IV.1.L.3.i and replacing those provisions with paragraphs 9 and 11 of the Amended VAWIR policy [relating to the pro-charge mandate].
14. Division VIR Policy be amended to provide that an investigating officer has discretion not to forward a RTCC recommending a charge when there are grounds to believe that a relationship offence has been committed but the only evidence is that of the complainant, who refuses to testify or otherwise cooperate with a prosecution.
15. Division VIR Policy be amended to provide that the following circumstances cannot be the basis for exercising a discretion not to forward a RTCC:
- i. The consumption of alcohol or the use of drugs by the victim or the suspect unless such consumption renders the evidence of the victim unreliable; and
  - ii. The lack of independent corroborating evidence, unless there are reasonable grounds for believing that the evidence of the victim is unreliable.
16. Division VIR Policy be amended to provide that a complete investigation in a relationship violence complaint include the following computerized index searches:
- CPIC computer searches:
  - “Persons”, “CNI”, Criminal Record, and “SIP” databases;
  - PIRS computer searches:
  - ED1 and ED2 databases and the databases of any other jurisdictions in which the suspect or victim have resided or worked in the previous seven years;
  - POR Registry; and
  - Vancouver, Victoria, and Esquimalt Police Departments computer records:
  - Whenever there is any information suggesting that, within the previous seven years, the suspect or victim has resided in the jurisdiction of one of the above municipal police forces, a search should be requested of that police department’s computer file index for any information relevant to the RCMP investigation.
17. Division VIR Policy be amended to require that the results of these searches be dated and recorded in the investigational file.
18. Division VIR Policy be amended to mandate that an investigating officer consider in each relationship violence case whether there are reasonable grounds for believing that it is not desirable in the interests of the safety of the victim or of any other person that the suspect possess or have custody or control of any firearm, such that the officer should either make application for a search warrant or, if there is a proper basis, search without warrant, to seize

any firearm, dangerous weapon, FAC or other firearms permit in the possession, custody and control of the suspect.

19. Division VIR Policy be amended to mandate that investigating officers record in the investigational file all relevant information that is received from the victim or other sources.
20. Division VIR Policy be amended to require that all documents received from a victim or other person in respect to a relationship violence investigation be date-stamped, initialled by the person receiving the document, and immediately brought to the attention of either the investigating officer or the on-duty supervising officer.
21. “E” Division embark upon a training initiative that will provide all general duty, GIS and supervisory personnel with training equivalent to that presently available in the Advanced Training Curriculum (Advanced Interview Skills) and Criminal Harassment Interdisciplinary Training programs recently developed by the Criminal Justice Branch of the Ministry of Attorney General, such training to be completed no later than December of 1999.
22. “E” Division establish a Task Force to design and plan the delivery of such a training initiative.

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#### **6.4.3. Honouring Christian Lee—No Private Matter: Protecting Children Living with Domestic Violence (BC Representative for Children and Youth, 2009)<sup>460</sup>**

Peter Lee and Sunny Park were married in 2004. They had one son, Christian, who was born in 2001. On September 4, 2007, Mr. Lee murdered his son, wife, and parents-in-law. He then committed suicide. The British Columbia Representative for Children and Youth, who is responsible for reviewing deaths of children receiving services from the province, reviewed the events leading up to Christian’s death.

The Review found that prior to the murders, Mr. Lee was involved with the police several times:

1. In 2003, Ms. Park called the Victoria police for a domestic dispute. Mr. Lee had allegedly pushed Ms. Park and Christian, who was a baby, when Ms. Park tried to prevent him from leaving the house to go gambling. Police settled the incident by having Mr. Lee leave the home for the night. No charges were laid.
2. In 2004, Mr. Lee allegedly assaulted a business colleague. No charges were laid.
3. In 2005, Mr. Lee was charged with assaulting a restaurant employee. Those charges were stayed.
4. Also in 2005, Mr. Lee was investigated for an arson fire at the restaurant. No charges were laid.
5. In July 2006, Mr. Lee was charged with uttering threats and unlawful confinement of a young man. This man had complained that he had not been hired at the restaurant that Mr. Lee and Ms. Park owned. Mr. Lee allegedly found the young man, forced him and his girlfriend into a car, forced the young man to do a series of bizarre exercises such as sprints in the water, and forced him to smash his own toe with a large rock. A court date was scheduled for October 2007.

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<sup>460</sup> “Honouring Christian Lee—No Private Matter: Protecting Children Living with Domestic Violence,” British Columbia Representative for Children and Youth (September 2009), [https://rcybc.ca/wp-content/uploads/2019/06/honouring\\_christian\\_lee.pdf](https://rcybc.ca/wp-content/uploads/2019/06/honouring_christian_lee.pdf).

6. On July 19, 2007, Ms. Park called the Oak Bay police and reported a domestic dispute. She and Mr. Lee were having a verbal argument. The police attended and found Ms. Park and Mr. Lee talking calmly in the home. Ms. Lee, her parents, and Christian spent the night in a hotel.
7. On July 31, 2007, five weeks prior to the murders, Mr. Lee crashed the family vehicle while Ms. Park was in the car. They had been arguing about Ms. Park's intention to divorce Mr. Lee when Mr. Lee drove the car into a utility pole. Ms. Park was seriously injured in the crash. Despite her language barriers and lack of confidence in her ability to speak English, Ms. Park told the police at the scene that the crash was intentional, and that Mr. Lee had been violent to her for many years. She reported intimidation, emotional and psychological abuse, physical abuse, and that he pressured her to have sex on many occasions. She said he had threatened to kill her and kill himself. She had not reported him to police before because she feared he would seriously harm or kill her. He had told her that if she ever tried to divorce him, he would kill "everybody" and then kill himself. She said she thought Mr. Lee was going to kill her and was worried about her parents and sister. She later said she feared Mr. Lee might try to harm Christian in order to cause harm to her. Mr. Lee was arrested and placed in custody, and the file was referred to British Columbia's Ministry of Family and Child Development (MFCD) for the first time. At that point, a social worker from the MFCD became involved.

The police recommended to the Crown that Mr. Lee be charged with aggravated assault and dangerous operation of a motor vehicle and be held in custody or, alternatively, with a cash bail requirement too high for Mr. Lee to meet. The police met with the Crown to emphasize their concerns for Ms. Park if he were released. The Crown appears not to have had all the information about the file and believed that there were inconsistencies in Ms. Park's statement suggesting that the crash was accidental. As a result, the Crown charged Mr. Lee with unlawfully causing bodily harm and dangerous driving causing bodily harm. The Crown did not believe he would be detained given his lack of a criminal record and past compliance with bail conditions. Mr. Lee was released on August 2, 2007 on consent, with conditions not to contact Ms. Park, not to visit the family home or the family's restaurant, and not to possess weapons, including knives. He was not prohibited from contacting Christian. At the time, Mr. Lee was also under additional bail conditions for the 2006 assault against a young man.

Following his release, Mr. Lee told a therapist that he had no money and nowhere to live and said he felt suicidal. He agreed to call the therapist if he needed immediate help. A few weeks later, he said he was feeling better. Ms. Park reported concerns about Mr. Lee breaching his bail conditions several times, as well as concerns that he was following her. He was warned on several occasions that he would be charged with breach. He also continued to ask Ms. Park's lawyer about the possibility of reconciling. During this time, the child protection worker assigned to the case had determined that Ms. Park was taking adequate steps to protect Christian.

Mr. Lee's criminal case was adjourned to September 4, 2007. In the early hours of that day, Mr. Lee broke into the home where Ms. Park, Christian, and Ms. Park's parents were living. He stabbed each member of the family. He told a 911 operator to send an ambulance and then stabbed himself. All died before police arrived.

The Report made an overall finding that:

The lack of a system-wide domestic violence response across criminal law, child welfare and family justice sectors, and the absence of a thorough and fully informed assessment

of the risk of harm and lethality posed by Peter Lee placed Christian Lee and Sunny Park in grave danger without an adequate safety plan.<sup>461</sup>

The Report also found that child protection services and the police did not effectively exchange information. In that context, the Report recommended Nova Scotia's model for high-risk case coordination. That protocol calls for coordination among three intersecting provincial systems: the Department of Justice, the Public Prosecution Service, and the Department of Community Services. The protocol identifies actions for each agency to take once a case is determined to be high-risk and creates better case coordination.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 1c) That the Ministry of Child and Family Development (MCFD) record and track child protection reports with domestic violence issues in order to evaluate effectiveness of safety planning and protection of children over time.
2. (Recommendation 2) That the Ministry of Public Safety and Solicitor General take the lead in a special initiative that focuses on the issue of safety of children and youth in domestic violence situations, by ensuring a coordinated, effective, and responsive system in Greater Victoria and throughout British Columbia.
3. (Recommendation 3) That the Ministry of Attorney General undertake a review and enact necessary changes to improve the administration of justice in criminal matters involving domestic violence, including establishment of domestic violence courts, to better protect the safety of children and their mothers.
4. (Recommendation 4) That the Ministry of Attorney General undertake a review and enact necessary changes to improve administration of justice in family law matters in domestic violence cases, to better protect the safety of children and their mothers and to ensure that the perspective of the child is considered.
5. (Recommendation 5) That MCFD strengthen services to immigrant women in circumstances of domestic violence.

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#### **6.4.4. Honouring Kaitlynn, Max, and Cordon: Make Their Voices Heard Now (BC Representative for Children and Youth, 2012)<sup>462</sup>**

In April 2008, Allan Mr. Schoenborn killed his three children, Kaitlynn (age 10), Max (age 8), and Cordon (age 5). Mr. Schoenborn and the children's mother had been in a common law relationship for fourteen years. Mr. Schoenborn worked as a roofer and was the sole financial provider. He also lived with mental health and addiction problems. The children's mother was not named in the report, which examined the services provided to the children prior to their deaths.

British Columbia's Ministry of Child and Family Development (MCFD) first had contact with the family on 14 June 1999. Mr. Schoenborn had crashed the car with Kaitlynn in it and rushed her to the hospital, claiming she had been poisoned and that her mother was sexually abusing her. Mr. Schoenborn was lawfully detained for mental health issues. On 21 June 1999, he left the

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<sup>461</sup> "Honouring Christian Lee," p. 33.

<sup>462</sup> "Honouring Kaitlynn, Max, and Cordon: Make Their Voices Heard Now," British Columbia Representative for Children and Youth (March 2012), [https://rcybc.ca/wp-content/uploads/2019/05/honouring\\_kaitlynn.pdf](https://rcybc.ca/wp-content/uploads/2019/05/honouring_kaitlynn.pdf).

hospital against medical advice. He was diagnosed with a delusional disorder and prescribed anti-psychotic medication.

Over the following years, the police and MCFD had numerous contacts with the family. Mr. Schoenborn had disputes with his neighbour and broke his brother's shoulder during an altercation while intoxicated. These incidents did not lead to charges. Mr. Schoenborn also broke the mother's nose in 2001, but she told the hospital it was an accident. In May 2007, the children's mother called the police and reported that Mr. Schoenborn had come home intoxicated and went on a "rampage" in the home, throwing and breaking things, yelling, and frightening the children. He punched out the kitchen window and told her she would be next. She fled to a payphone and called police while the children were still in the home. She told the police she lived in fear of Mr. Schoenborn and was worried he would have beaten her to death. She believed his anger was escalating and wanted to end the relationship. She requested a restraining order. She also reported that Mr. Schoenborn had sexually assaulted her for hours two days earlier and threatened to "beat her black and blue" if she refused. He was intoxicated. One of the children came into the room during the assault. Mr. Schoenborn was charged with uttering threats and sexual assault.

Over the following months, Mr. Schoenborn continued to have contact with the mother and the children. The mother asked for the bail conditions restricting his contact to be lifted. She felt that jail would not help him, and he would not get better while facing charges. Officers tried to help her understand the seriousness of the violence and the impact it had on her children. In July 2007, the mother contacted Crown counsel to recant all of the sexual abuse allegations she had made against Mr. Schoenborn. She later told the Representative for Children and Youth that Mr. Schoenborn had coerced her into doing this, partly because he believed that she and the police and MCFD were "all out to get him." She felt she had to recant to ease the pressure he was placing on her. The Crown stayed the sexual assault charges against Mr. Schoenborn, and Mr. Schoenborn entered into a peace bond instead. The peace bond did not restrict his contact with the family. One day later, Mr. Schoenborn was arrested for being drunk in public and charged with breaching the no-alcohol provision of his bail conditions. His bail conditions prohibited contact with the mother after having consumed alcohol and prohibited the possession of weapons.

The MCFD learned in August 2007 that Mr. Schoenborn was going to the home every day. He was not involved with any supportive services and had not met with any workers. A worker faxed him a note, outlining services and stating that he should get involved with services and speak to a worker before moving back into the home. The MCFD did not take any other steps to intervene, despite the fact that his presence in the home was contrary to a risk reduction plan that the MCFD had developed for the family. On 23 August 2007 Mr. Schoenborn came to the home, started drinking, and went into a jealous rage. The mother locked him out of the home and phoned police. Before they arrived, Mr. Schoenborn broke into the home. He was charged with breaching the peace bond. The children were present during this incident. Mr. Schoenborn was released with the same conditions as in the peace bond. The MCFD conducted a high-risk assessment, concluding that the safety options were either to have the family move to a transition house or to remove the children. Over the next few weeks, the mother and children moved around. Mr. Schoenborn continued to come to the home. The mother said she did not want to go to a transition house because she would not be able to take the children's dog. The mother and children agreed to go to a relative's home, without Mr. Schoenborn. One of the MCFD workers told a colleague that day that she believed Mr. Schoenborn would kill the mother in front of the children. However, she and her colleagues approved Ms. Schoenborn's plan to move and did not take any steps to initiate court proceedings or remove the children from the home. The following month, the MCFD asked the Interior MCFD to provide "courtesy services" and advised them that the father's actions

had been dangerous and life-threatening and that the mother minimized the violence and its impact on the children.

Over the following months, there was a lack of clarity as to which MCFD office had responsibility for the family. Mr. Schoenborn was charged with impaired driving. There were reports that he was living with the family, but MCFD did not take significant steps in response. The mother was in financial crisis between January and March of 2008. She was given crisis grants but was warned that these may not be approved in future. Mr. Schoenborn also sought income assistance at the end of March 2008. It became clear that Mr. Schoenborn was confused as to whether he was permitted in the home.

On April 1, 2008, Mr. Schoenborn went to the school and said he was worried the mother would flee with the children and that he was worried about the children. The school called MCFD. That same day, a community member reported that Mr. Schoenborn had been living at the home. Mr. Schoenborn went to the MCFD office that day. It was clear that Mr. Schoenborn was confused about MCFD's expectations as to his contact with the children and their mother, which he referred to as an "order." Police attended at the meeting after learning that Mr. Schoenborn was living at the home. Mr. Schoenborn was agitated by their presence. The police arrested him for an outstanding warrant for driving while prohibited, and the meeting ended.

The following day, Mr. Schoenborn appeared in court in a neighbouring city and was released on supervised bail with standard conditions. His bail supervisor did not observe anything indicating a mental health concern. Mr. Schoenborn then tried to take a bus to the city where his family was living. He was intoxicated and agitated and got into altercations with a passenger and a driver. He arrived in the city where his family was living and was arrested for public drunkenness while loitering in the police station parking lot. He was released later that day with a ticket. Police said they did not note any signs of mental illness. He again went to the school, and a school staff member observed that he was more anxious and disheveled than he was two days earlier. He was over-reacting, not making sense, and "falling apart." He demanded to be taken to his daughter's class; she came out of the class and said hello to him. He said he felt assured she was ok and left the school. He came twice more that day and threatened a child he believed was bullying his daughter. He called police, and the school called police as well. An officer spoke with Mr. Schoenborn and was able to calm him down.

Mr. Schoenborn was arrested for uttering threats to his daughter's schoolmate and taken into custody. He had to be restrained from bolting, but the officers believed he was scared but coherent and cooperative. A bail hearing was held by telephone that same day. The officer requested that Mr. Schoenborn be detained over the weekend and reviewed his criminal history and history of failing to appear. However, the officer did not refer to the previous domestic violence incidents, the fact that there was a peace bond in place, or the child protection concerns. The officer incorrectly said there was an application for a peace bond. Mr. Schoenborn said he would reside with his children and their mother and that he had been living there the prior three days. The justice of the peace asked if there was any friction between the mother and Mr. Schoenborn. Mr. Schoenborn said, "No." The justice of the peace thought that the person who said "no" was the officer. Mr. Schoenborn was released that same day, with conditions to not attend at the school or have contact with the student who was threatened. No notice of his release was given to MCFD, the mother, the school or the family of the child he had threatened. The justice of the peace told Mr. Schoenborn, "You've got a break on this."

The children's mother told the Representative for Children and Youth that during that week, Mr. Schoenborn grabbed her by the neck and threw her against the wall, threatened her, and the look

in his eyes was different, as if it wasn't him. She was more terrified than usual. Mr. Schoenborn had not yet received income assistance. Because Mr. Schoenborn and the mother believed he was not permitted to be with the children in her presence, the mother agreed that he could live in the home without her there. She went to a relative's home for the weekend. Mr. Schoenborn remained at the home with the children. She spent some time with the children on 5 April, separate from Mr. Schoenborn. She went to her relative's home that evening. Mr. Schoenborn called her several times that evening, begging her to come home and reconsider their separation. She said she was tired of constant fighting, and it wasn't good for the children. The last call took place close to midnight.

After Mr. Schoenborn put the children to bed, he killed them. He said at trial that he had become suspicious that they were being groomed for prostitution and believed no one could protect them. He decided to "put them where they are safe." He wrote the words "forever young" on the kitchen wall. He was found in the bush a week later. The BC Supreme Court found him not criminally responsible on account of mental disorder.

The Representative for Children and Youth made the following overall finding:

The deaths of these children were preventable. These children were extremely vulnerable to violence and harm due to the domestic violence in their home, and their father's untreated mental illness. Countless opportunities to ensure that the children and their mother were safe were missed because of a profound lack of coordination among the child-serving, mental health and criminal justice systems over many years, compounded by glaring failures in child protection practice, and an inability to recognize and assess the extent of the father's mental illness....

By their very nature, complex cases (which in this particular situation included untreated parental mental illness, domestic violence and substance abuse) require a high degree of collaboration amongst different service providers working in multiple systems. That did not happen in this case. This family required a coordinated approach that allowed for professionals to be able to share information and plan together to address risk assessment findings and risk management requirements.<sup>463</sup>

The Report noted that the mother was trapped in an abusive relationship and that the child protection system placed unbearable pressure on her to protect her from their father but provided her with little support to do so. The Representative for Children and Youth stated, "All too often fathers are invisible in the child protection system, and the focus is on the mother to manage difficult circumstances to protect her children."<sup>464</sup> The MCFD did not engage the father in the risk reduction safety plan and did not offer him services to improve his social and emotional functioning and reduce the risk to the mother and children. The children also never received services that were promised to them, such as a program for children who witness violence.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

That the Ministry of Health, in partnership with the Ministry of Children and Family Development, take immediate steps to ensure that all staff and professionals connected to their systems understand the risk factors relating to children of parents with a serious untreated mental illness, and promote the well-being of children by

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<sup>463</sup> "Honouring Kaitlynnne, Max, and Cordon," p. 56.

<sup>464</sup> "Honouring Kaitlynnne, Max, and Cordon," p. 59.

- a. putting in place procedures for the identification at intake in the health care system or child-serving system of the parental role of people with a mental illness, including expectant parents
- b. developing and implementing policies and procedures to support workers to identify and reduce risk factors for children affected by parental mental illness and domestic violence
- c. ensuring appropriate information regarding referral to services for families affected by parental mental illness without abdicating the focus on child safety
- d. developing and implementing policies for early detection of risk factors for families associated with mental illness (e.g., social isolation, frequent moves, emotional and financial instability, violent episodes).

Improvements should include:

- Policies and standards for identifying and managing cases where serious parental mental illness may jeopardize the safety and well-being of children, taking into account concurrent substance abuse
- Provision for an active outreach and monitoring program across the province, and identifying and monitoring for factors which may increase the risk
- Ensuring that children who have been traumatized are referred to and engaged with the child and youth mental health system
- Provision for a consultation service for social workers and other professionals involved with the child so that they can better understand the dynamics in the home
- Mechanisms to ensure effective links with child protection and child and youth mental health services at the local level
- Ensuring this report will be used to promote practical learning in the adult mental health system across the province and among policy staff in the ministry.

## 6.5. Ontario

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### 6.5.1. Inquest into the Death of Margret Kasonde and Wilson Kasonde (Ontario, 1997)<sup>465</sup>

In May 1995, Robert Kasonde shot and killed two of his children, Margaret and Wilson, in front of his third child, Geoffrey. He had mental health issues, and his wife had left the relationship because he was abusive to her and the children. He had shared custody of one of the children, Geoffrey, and regular access to the other children.

Community members made numerous reports of concern about the safety of the children to the local children's aid society. However, those reports were not shared with police. Three years before the killings, in July 1992, a neighbour reported concerns to police about Mr. Kasonde's possession of a gun. Around the same time, the children's mother reported to the police that she had heard secondhand that Mr. Kasonde had threatened to shoot himself with the rifle. The rifle was seized but returned to Mr. Kasonde the following month. In the months preceding the killings,

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<sup>465</sup> "Verdicts of the Coroner's Jury Serving on the Inquest into the Deaths of Margret Kasonde and Wilson Kasonde," Ontario (June 1997).

Margret, who was 8, repeatedly told her teacher that she was afraid of her father and one on occasion said that he would “get the gun.” The teacher reported this to the Children’s Aid Society (CAS). A social worker from the children’s hospital also reported concerns about Mr. Kasonde to the CAS, calling him a “ticking time bomb.” Two months before the killings, Margret repeated her concern about her father’s gun to a CAS worker. At the time of the shootings, Ms. Kasonde was attempting to obtain sole custody of the children with only supervised access to their father. The case was under ongoing investigation by the CAS at the time.

There were significant problems with the child protection response to the family, including a lack of resources, a lack of training on domestic violence, a lack of information-sharing about the family, a practice of only communicating with the mother even though the father also had care of the children, repeated transfers between workers, poor risk assessment, a failure to investigate reports of abuse, and a lack of cultural competency. (The family was from Zambia.)

The coroner’s jury made 74 recommendations, largely related to child protection services.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 7) Change and clarify confidentiality and privacy provisions to allow ongoing sharing of information between Children’s Aid Societies (CASs) and other professionals providing service to children.
2. (Recommendation 19) Amend the existing regulations and standards of the Revised Standards for Investigation of Child Abuse Case to allow the CASs to share the results of their investigations and information available to them with all organizations and professionals who are expected to monitor and/or support the safety and well-being of the child, as long as it is considered necessary to ensure safety and to plan services for the child.
3. (Recommendation 60) Develop a broad-based public awareness and education program addressing the needs of vulnerable children and youth, early identification of abuse and neglect indicators, and the duty to report.
4. (Recommendation 62) Implement the Department of Justice Firearms Registry without delay.
5. (Recommendation 63) Amend relevant federal legislation to allow permanent removal of lethal weapons, firearms, and permits from the possession of any individual where there is a threat of suicide, domestic violence, or child protection concerns and to place a CPIC alert on such individuals.
6. (Recommendation 64) Require that police/CAS protocols for investigations include specific provisions for the management of child protection cases where firearms and/or lethal weapons are present.
7. (Recommendation 65) Require face-to-face consultation between police, family, and CAS prior to return of any weapon.
8. (Recommendation 66) Require a Case Planning and Review Conference for every case in which there is a history of domestic violence and a firearm/lethal weapon known to be in the home.
9. (Recommendation 69) An occurrence report must be made and filed in any situation in which the police respond to an incident involving domestic violence or any CAS investigation.
10. (Recommendation 70) When police attend an incident involving a CAS investigation, the police report must be cross-referenced to the CAS file.

11. Chief Coroner of Ontario provides the Jury with a report on the status of the recommendations within 12 to 18 months, and that this report be made public.

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### **6.5.2. Inquest into the Deaths of Arlene May and Randy Iles (Ontario, 1999)<sup>466</sup>**

In March 1996, Randy Iles killed his ex-girlfriend, Arlene May, in Collingwood, Ontario. Mr. Iles then committed suicide.

Mr. Iles had a history of violence. In two previous marriages, there were instances of child abduction, stalking, and threats with a weapon. In addition, Mr. Iles had criminal convictions for indecent exposure, harassing phone calls, breach of probation, possession of stolen property, and a weapons offence for which he had a five-year prohibition order. Mr. Iles was also involved in a number of custody disputes in Family Court. The violence in Mr. Iles' and Ms. May's relationship appears to have begun when Ms. May became pregnant. She delivered a stillborn infant in 1995. In February 1996, Mr. Iles was arrested for assaulting Ms. May and was released on condition that he leave the jurisdiction. His bail conditions also required him to surrender his Firearms Acquisition Certificate; however, he did not do so. Mr. Iles moved his family to the Oshawa area. He contacted Ms. May, in breach of his bail conditions. On 7 March 1996, Mr. Iles' lawyer informed him that there was an outstanding warrant for his arrest. The next day, Mr. Iles bought a gun from a store in Oshawa, using his Firearms Acquisition Certificate. He drove to Ms. May's home. Ms. May's children were at home. Mr. Iles locked the children in a closet for hours and later told them to go to the corner store to call the police. When police arrived, they found Ms. May and Mr. Iles dead in her bedroom.

The Coroner's inquest began on February 16, 1998. Following the evidence, the jury deliberated for ten days. The jury made 213 recommendations.

#### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 68) The Government of Ontario must consider specifically funding programs for small municipal police services and for other service providers in smaller urban or rural areas, to ensure the availability of adequate resources to address all issues related to domestic violence. All police forces must be trained to the same standard.
2. (Recommendation 73) The Behavioural Science Unit, OPP [Ontario Provincial Police] should, in consultation with representatives from shelters, Victim Services, and other authorities in the field of domestic violence, develop a risk assessment instrument and a lethality checklist. These should be used by the investigating police officers in all cases of domestic violence as a reminder of important matters to consider, such as whether the accused has access to firearms and/or possesses a FAC [Firearms Acquisition Certificate].
3. (Recommendation 76) The Solicitor General of Ontario should issue a directive encouraging Police to use their authority under Section 103 of the Criminal Code to search and seize weapons and FACs from an individual for safety reasons in domestic violence cases.
4. (Recommendation 91) The Federal government is encouraged to bring into force on October 1, 1998 the firearm licensing provision of Bill C-68, notwithstanding any delays which may occur due to litigation involving the gun control and registration portion of the legislation.

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<sup>466</sup> "Report of the Inquest into the Deaths of Arlene May and Randy Iles," Office of the Chief Coroner of Ontario (September 1999).

5. (Recommendation 92) If regulations associated with C-68 federal gun control legislation are not implemented as scheduled, firearm acquisition officers in Ontario should be directed by written policy to conduct a full investigation into applications for FACs, including interviews of all references and current and former partners, criminal history search with specific focus on violent and domestic related charges, lethality assessment factors, suicide attempts, contact with relevant community professionals, etc.
6. (Recommendation 93) All police officers in Ontario must receive training on the new firearms legislation and policy, with particular focus on domestic violence issues.
7. (Recommendation 94) The policy and procedures of Police Services should direct that whenever an application is made for an FAC, the Police Service that conducts the background investigation shall create an occurrence report. The occurrence report should be entered on OMPPAC [Ontario Municipal and Provincial Police Automation Co-operative] or other computer system utilized by the police services, regardless of whether the application is granted or refused, in order that information is made accessible to other Police Services.
8. (Recommendation 95) Police to regularly monitor sellers of firearms for compliance to the latest legislation.
9. (Recommendation 96) It is recommended that the authorization to purchase an unrestricted firearm as required by the draft provisions of Bill C-68 must be delayed for up to seven days to be certain that the "firearm interest person" (FIP) record system has been updated to include all firearm prohibition orders.
10. (Recommendation 97) All police officers involved in the investigation of domestic violence must be trained and instructed to make a check with the Chief Provincial Firearms Officer to ascertain whether an accused has a firearm acquisition certificate.
11. (Recommendation 98) The issuance of a warrant to arrest an accused should automatically trigger the suspension of an FAC.
12. (Recommendation 99) The Ministry of the Attorney General must ensure that Crown Attorneys receive training on the new federal firearm licensing and registration provisions of Bill C-68.
13. (Recommendation 100) The Ministry of the Attorney General, as part of its education plan, must ensure that every Crown Attorney knows how to check or to arrange to check to see if someone has a firearm acquisition certificate.
14. (Recommendation 101) Checking for FACs and consideration of an FAC ban as a bail condition must be mandatory in domestic violence cases.
15. (Recommendation 102) The police should be directed to ask accused and victims of domestic violence about the existence of a firearms acquisition certificate, firearms, or possession of other lethal weapons, in every domestic violence case; and that further, Police should check the accuracy of facts such as address and phone number prior to preparing for the bail hearing.
16. (Recommendation 103) Where victims indicate the accused has a gun, Police should investigate fully the possession of firearms and FACs, including contacting additional partners of the accused known to police, checking computer databases, and seeking warrants to search vehicles and premises, including workplace, etc., pursuant to Section 103 of the Criminal Code of Canada.
17. (Recommendation 104) In all instances where an accused is charged with an offence involving domestic violence, the police shall recommend a firearms/weapons prohibition, and an order

directing the accused to surrender his firearms acquisition certificate and weapons be requested.

18. (Recommendation 105) Where an accused is ordered to surrender an FAC and/or weapons, procedures should call for immediate enforcement by the police.
19. (Recommendation 155) The Government of Ontario, should through appropriate Ministry budgets, provide funding to professional educational institutions and bodies for the early training of all community professionals in contact with abused women and their children. This would include doctors, mental health professionals, teachers, lawyers, social workers, social assistance caseworkers, early childhood educators, etc.
20. (Recommendation 156) The Law Society of Upper Canada should incorporate domestic violence training, including lethality assessment and safety planning, into all relevant sections of its Bar Admission materials.
21. (Recommendation 157) The Ministry of Education and Training should ensure that issues of domestic violence and its impact on children be integrated into curriculum at all levels from junior kindergarten to high school graduation.
22. (Recommendation 158) School Boards should be required to provide programming within the schools of their districts to teach adolescents the meaning of healthy relationships free of the exercise of power and control, coercion, and violence.
23. (Recommendation 159) School boards and the schools within their districts must adopt a program of zero tolerance against violence by integrating violence prevention programs into the school curriculum.
24. (Recommendation 160) Strategies must be developed within the educational system to identify children who are at risk because of direct or indirect exposure to domestic violence. Appropriate referrals to services that will promote safety and healing for the child should be made.
25. (Recommendation 161) Educators must be trained to foster a climate within schools to encourage children to disclose the violence in their lives.
26. (Recommendation 194) The Attorney General should ensure that all Crown Attorneys in the prosecutorial service receive training in the dynamics of domestic violence, the cycle of violence, and the power and control exercised within intimate relationships. Further, Crown Attorneys who deal with cases of domestic violence must be trained to use strategies to prosecute cases without the necessity of victim cooperation or participation. The training should include:
  - i. Knowledge of the relevant law;
  - ii. A casebook of the current thinking of leading authorities and experts on the magnitude of domestic violence in Canada, battering theories, and the emotional and physical harm that domestic violence causes victims;
  - iii. Techniques for the vigorous and successful prosecution of difficult cases, such as the use of “KGB” videotape statements, photographs of injuries, 911 audio taped emergency calls;
  - iv. A thorough familiarity with the relevant provisions of the Crown policy manual dealing with bail, spousal/partner abuse, firearm/weapons offences, and criminal harassment;
  - v. The use of risk assessment instruments and lethality checklists;
  - vi. The use of expert evidence;
  - vii. Effective interview techniques and active listening skills;

- viii. The effective use of Victim Services available through the Victim/Witness Assistance program and/or community-based victim service programs; and
  - ix. Training on arguing the right of abused women under Sections 7 and 15 of the Charter of Rights and Freedoms.
27. (Recommendation 195) There should be adherence to the Yeo inquest recommendations (summarized above in section 3.2.) pertaining to training of Crown Attorneys regarding bail hearings and effective advocacy, with emphasis on those issues in the context of domestic violence cases.
28. (Recommendation 196) There should be more education and training opportunities for Crown Attorneys both within the criminal law division and outside professional organizations such as the Canadian Bar Association, the Law Society of Upper Canada, Advocate Society, and the Federation of Law Societies. In particular, the Crown Attorneys Fall Conference should be restored as a compliment to the Spring Conference and the Crown Attorneys Summer School.
29. (Recommendation 197) The Attorney General should develop an evaluation tool to periodically evaluate the effectiveness of training end to identify training needs with respect to domestic violence. The tool should also identify the extent to which training is implemented by Crown Attorney/Assistant Crown Attorney in daily practice.
30. (Recommendation 198) The Attorney General should develop any new Crown training materials on domestic violence in collaboration with independent frontline, community-based women's advocates.
31. (Recommendation 199) The Attorney General should endeavour to arrange presentations in domestic violence training situations by independent, community-based women's and children's advocates and survivors of domestic violence.
32. (Recommendation 200) The Ministry of the Attorney General should ensure that all children's lawyers, all lawyers on the provincial panel dealing with parent-child relationships and all family court child assessment professionals receive training on issues of domestic violence and its impact on children, in collaboration with independent, community-based children's and women's advocates, including training on compounding issues such as race, culture, language, disability, sexuality, etc.

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### **6.5.3. Inquest into the Deaths of Gillian Hadley and Ralph Hadley (Ontario, 2002)<sup>467</sup>**

In June 2000, Ralph Hadley shot and killed his estranged wife, Gillian Hadley, and then himself. Ms. Hadley had two small children from a previous relationship and an eleven-month-old baby with Mr. Hadley.

In the six months before the murder-suicide, Mr. Hadley had at least three encounters with police, all involving violence or threats against Ms. Hadley. He had also reportedly been talking about suicide. Mr. Hadley was charged with assaulting Ms. Hadley earlier in 2000 and was later charged with criminal harassment after stalking her. He was released on bail and ordered to live at his parents' home under 24-hour supervision and to have no contact with Ms. Hadley.

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<sup>467</sup> "Inquest Touching the Deaths of Gillian Mary Hadley and Ralph Alexander Hadley: Jury Verdict and Recommendations", Chief Coroner, Province of Ontario (February 2002)

On the day of the murder-suicide, Mr. Hadley went to their house in Pickering, Ontario with a knapsack containing a gun, ammunition, and a suicide note. Ms. Hadley ran naked and screaming from their house and managed to hand their baby to a neighbour before Mr. Hadley dragged her back into the house and shot her and then himself.<sup>468</sup> A coroner's jury made 58 recommendations following several weeks of testimony.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. (Recommendation 1) We recommend that an implementation committee be established by the Government of Ontario, consisting of government and non-government representatives, to oversee the implementation of the recommendations in the inquest into the deaths of Gillian Hadley and Ralph Hadley, the inquest into the deaths of Arlene May and Randy Iles [summarized above in section 6.5.2.), and the recommendations arising out of the report by the Joint Committee on Domestic Violence to the Attorney General of Ontario entitled "Working Toward a Seamless Community and Justice Response to Domestic Violence: a Five Year Plan in Ontario."<sup>469</sup>
  - a. We also recommend that half the Implementation Committee be chosen from community-based women's and children's advocates and survivors of violence, as well as community-based representatives with expertise on issues of domestic violence who are representatives of diverse communities in Ontario; and that OAITH, the John Howard Society, and representatives of the subsidized housing sector be included in this group.
  - b. And further, that the work of the Implementation Committee be funded and not time-limited, and that it continue until the Committee is satisfied that all recommendations have been implemented across the province.
2. (Recommendation 2) We recommend that the Ministry of the Solicitor General conduct audits of police services to monitor compliance with the Model Police Response to Domestic Violence.
3. (Recommendation 3) We recommend that the Ministry of the Solicitor General enhance the curriculum for recruit training at the Ontario Police College in order to produce a qualified domestic violence investigator at graduation in every case. No fewer than forty (40) hours should be spent on domestic violence investigative training.
4. (Recommendation 4) We recommend that the Ministry of the Solicitor General emphasize the importance of and encourage police services to use the Domestic Violence Supplementary Report Form when investigating domestic violence incidents.
5. (Recommendation 7) We recommend that investigating officers who respond to domestic violence complaints conduct their investigations without requiring the complainant to obtain statements from others or to gather evidence as a means of completing the investigation.

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<sup>468</sup> These facts are taken from media reports at the time of the murder-suicide and inquiry. See "Closing Arguments at Hadley Inquest" *CBC News* (24 January 2002), <https://cbc.ca/news/canada/toronto/closing-arguments-at-hadley-inquest-1.337395>; T. Appleby, "Inquest Called into Pickering Tragedy" *Globe and Mail* (30 June 2000), <https://theglobeandmail.com/news/national/inquest-called-into-pickering-tragedy/article1040914/>; and "Suicide Note Found in Murder-suicide Case" *CBC News* (23 June 2000), <https://www.cbc.ca/news/canada/suicide-note-found-in-murder-suicide-case-1.234301>.

<sup>469</sup> Joint Committee on Domestic Violence. Working Toward a Seamless Community and Justice Response to Domestic Violence: A Five Year Plan for Ontario. Report to the Attorney General. 1999

6. (Recommendation 8) We recommend that the Criminal Law Division form a training faculty of experts, including Victim/Witness Assistance Program, to advise and train Crown Attorneys on issues related to domestic violence and bail hearings, and that these training initiatives include monitoring and evaluation.
7. (Recommendation 9) We recommend that the Ministry of the Solicitor General direct all police services by written policy that release directly from a police service with undertakings and conditions on charges stemming from an incident of domestic violence is not an acceptable practice.
8. (Recommendation 10) We recommend that the Criminal Code be amended to require a reverse onus bail hearing in every domestic violence arrest situation.
9. (Recommendation 40) We recommend that the Ontario Association of Interval and Transition Houses (OAITH) and Ontario Association of Children's Aid Societies (OACAS), in collaboration with the Ministry of Community and Social Services, develop a specific response within child protection services across the province to child welfare reports and cases in which child exposure to domestic violence has been identified; and further:
  - a. That the Ministry of Community and Social Services ensure that appropriate and adequate funding is allocated to both the violence against women sector and the child welfare sector for training, implementation, and ongoing operation of the specific response in cases of domestic violence.
10. (Recommendation 46) We recommend that the Ontario Women's Directorate continue to work with community organizations and experts in the field of domestic violence to identify and promote public education messages and initiatives that would best improve public understanding of issues relating to women's safety.
11. (Recommendation 47) We recommend that the Government of Ontario, in collaboration with frontline women's and children's advocates in the field of women's shelters, fund the development of a public education campaign with the goal of making both the public and abused women aware of the children's programs and supports within women's shelters across Ontario to allay the fears of women who delay or decline using women's emergency shelters.
12. (Recommendation 50) We recommend that local domestic violence coordinating committees be established in every jurisdiction in the Province of Ontario with a view to coordinating services not just for those matters that enter the justice system but to coordinate services for all victims of domestic violence, including the indirect victims of domestic violence such as children.
13. (Recommendation 51) We recommend that the Government of Ontario Create a provincial coordinating committee comprised of Government and non-government representatives to assist in coordinating province-wide services to all victims of domestic violence, as well as to set standards and best practices.
14. (Recommendation 52) We recommend that the Government of Ontario organize and coordinate provincial and regional inter-sectoral conferences or symposia on domestic violence within the next six months.
15. (Recommendation 57) We recommend that the Government of Ontario and Government of Canada develop a database of those individuals who have not necessarily been convicted but have had arrests and charges laid with respect to domestic violence.

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#### 6.5.4. Inquest into the Deaths of Lori Dupont and Marc Daniel (Ontario, 2007)<sup>470</sup>

Lori Dupont was a registered nurse who worked at a hospital in Windsor, Ontario. Dr. Marc Daniel, an anesthesiologist at the same hospital, murdered Ms. Dupont on November 12, 2005. He died days later from a self-inflicted drug overdose. Dr. Daniel and Ms. Dupont were previously in a relationship. Ms. Dupont had taken steps to end her relationship with Dr. Daniel in February 2005, after he attempted to commit suicide as a controlling gesture over her.

Dr. Daniel had a history of abusive conduct, including fracturing a nurse's finger, verbal abuse, unprofessional behavior, and refusal to work with a specific nurse, although there was reluctance to complain about him because of fear of retaliation. There was also a sentiment in the workplace that management was nonresponsive to complaints against physicians. Despite these significant and documented complaints, there appeared to be "confusion and indecision" as to how to handle the complaints.<sup>471</sup> At the time, the Public Hospital Acts only envisaged discipline measures for physicians with regards to patient diagnosis, care, or treatment and not conduct that impacted hospital staff.

Ms. Dupont applied for a peace bond against Dr. Daniel in April 2005. Dr. Daniel had taken a leave from the hospital but returned to work in late May 2005 and continued to pursue Ms. Dupont. Although his harassment and stalking behaviours were known to people in the workplace, Dr. Daniel was allowed to continue to work in the same areas as Ms. Dupont.

Dr. Daniel stabbed Dupont to death at their workplace on November 12, 2005. A coroner's inquest commenced in September 2007 and issued twenty-five recommendations in December 2007.

#### Recommendations Relevant to the Mandate of the Mass Casualty Commission

1. (Recommendation 1) There should be a review, conducted on a priority basis, of the Public Hospitals Act (PHA), with a view to examining the hospital–physician relationship to ensure safe and quality of care in hospitals. This detailed review should involve various stakeholders, including but not limited to the Ontario Hospital Association, the Ontario Nurses' Association, the Ontario Medical Association, and the College of Physicians and Surgeons of Ontario (CPSO), and should have the goal of ensuring and promoting the safety of staff and patients as well as the quality of care in Ontario's public hospitals. The following principles and considerations, raised by the evidence at this inquest, should be addressed.
  - a. Ensure that patient and staff safety, as well as patient care, must be the most important factors and not be superseded by a physician's right to practice; and that hospitals be able to exercise the appropriate degree of authority over physicians working within their institutions, consistent with that of other regulated health professionals.
  - b. Review the parameters for the approval of credentialing applications and for reappointments to the medical staff.

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<sup>470</sup> "Dupont Inquest: Coroner's Jury Recommendations," Office of the Chief Coroner of Ontario (December 2007), <http://www.oaith.ca/assets/files/Publications/Coroners-Jury-Recommendations-Dupont.pdf>. Only the jury's recommendations are available. The majority of the facts of this case are not set out in the inquest report. The rationale provided for the recommendations sets out some of the facts. The majority of the facts have been provided by a summary from counsel for the Ontario Nurses' Association, except where otherwise noted: J. Fogels and E. McIntyre, "Coroner's Inquest Makes Recommendations on Workplace Violence Arising out of the Murder of Nurse Lori Dupont" *Cavalluzzo* (1 December 2007), <https://cavalluzzo.com/resources/publications/publication/coroner-s-inquest-makes-recommendations-on-workplace-violence-arising-out-of-the-murder-of-nurse-lori-dupont>.

<sup>471</sup> "Dupont Inquest: Recommendations," p. 2.

- c. Develop a process or mechanism for the early identification of and response to disruptive physician behaviour, including timely and effective disciplinary actions.
  - d. Simplify the process for non-approval of re-appointment, immediate suspension, or revocation of hospital privileges and for the initiation of probationary status.
  - e. Following an investigation by a Hospital Board or Medical Advisory Committee regarding serious complaints, including disruptive physician behavior affecting quality of patient care and/or patient and staff safety, non-approval of re-appointment, immediate revocation, suspension, and initiation of probation status should be implemented.
  - f. ....
  - g. Make available to hospitals the service of an “ombudsman” [sic] who would have the power to receive complaints about physicians, conduct investigations, report back as appropriate, and grant remedies.
  - h. The PHA should (either through the Act itself or through enabling regulation governing hospital bylaws) explicitly recognize the application of the Occupational Health and Safety Act (OHSA) and the Ontario Human Rights Code (OHRC) to physicians with privileges at public hospitals when the behaviour of physicians negatively impacts on the staff of the hospital.
2. (Recommendation 4) It is recommended that all workplaces design and implement a policy to address domestic violence (also known as intimate partner violence) and abuse or harassment as it relates to the workplace. Policies must be linked to training and actual practice. The principles and considerations that should inform the review of policies in this regard include the following matters that have been raised by the evidence in this inquest:
- a. Education of employees/workers/staff about the issues of domestic violence and abuse or harassment in order to help them identify an abusive relationship in which they may be involved and about how to reach out to coworkers for assistance. The policy at each workplace should reflect an analysis of the power differentials that exist between different groups of employees/workers/staff.
  - b. Mediation should not be utilized for incidents of violence or abuse because of the power imbalance between the parties in these circumstances...
  - c. Training of employers and managers [...] to identify signs of abuse and to respond appropriately to employees/workers/staff who are victims and to perpetrators of domestic violence.
  - d. All employees/physicians who are not directly involved may report a concern, but must report witnessed abusive or violent behavior [...]
3. It is recommended that there be a review of the Occupational Health and Safety Act to examine the feasibility of including domestic violence (from someone in the workplace), abuse, and harassment as factors warranting investigation and appropriate action by the Ministry of Labour when the safety and well-being of an employee is at issue. Specifically, the review should consider whether safety from emotional or psychological harm, rather than merely physical harm, ought to be part of the mandate of the Ministry. In this regard, the review should be directed to include an examination of the legislation and policies in place in other comparable jurisdictions, in Canada and elsewhere.
4. (Recommendation 8) It is recommended that all health care disciplines throughout their pre-service and ongoing professional development receive education in the dynamics of domestic violence and risk assessment and intervention strategies. This training should include an understanding of lethality factors and the use of standardized risk assessment tools to use when members are treating clients who may be victims or perpetrators of domestic violence, including those who present with symptoms of depression, especially following an intimate relationship breakup and/or suicide attempt.

5. (Recommendation 9) The Medical schools, the CPSO [College of Physicians and Surgeons of Ontario], the Ontario Psychiatric Association, the College of Psychologists, and the College of Nurses should give Continuing Professional Development credits for training in the areas of violence in the workplace, harassment, bullying, and domestic violence.

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### **6.5.5. Inquest into the Deaths of Vu Duy Pham and Frederick Preston (Ontario, 2012)<sup>472</sup>**

This inquest examined the shooting deaths of an Ontario Provincial Police (OPP) officer, Vu Duy Pham, and the man who shot him, Frederick Preston, on 8 March 2010.

Fred and Barbara Preston and his wife were married for 48 years. He was reported to be very controlling. There were incidents of physical and emotional abuse but no reports to police. They separated in 2009. In early March 2010, Ms. Preston was at her daughter's house while the daughter was away. Mr. Preston was looking after the animals in their daughter's barn. He became angry, broke into their daughter's house, and threatened that if Ms. Preston refused to reconcile, he would kill both of them or someone close to Ms. Preston, such her sister. Ms. Preston fled to a shelter. She did not tell shelter staff what happened. She told her other daughters of the events on the following day, 6 March 2010. Over the next 24 hours, the daughters and a son-in-law spoke to Mr. Preston several times. As they spoke to him, he continued to get angrier and more aggressive.

Mr. Preston left the area late on 7 March 2010. The following morning, he called the daughters and asked them to give their mother a message. They determined that he was calling from their mother's sister's home in Huron County, five hours away from where Mr. Preston had last been seen. They called back and asked to speak to their aunt, but Mr. Preston would not permit them to. Mr. Preston's son-in-law then called the police to ask them to do a wellness check on the aunt and their family. Constable Pham spoke to the son-in-law and learned that Mr. Preston had registered firearms, but they were locked in a cabinet at his house. Constable Pham and another officer went to the aunt's house and determined that no one was home. After leaving the home, Constable Pham spotted Mr. Preston's vehicle. Constable Pham pulled Mr. Preston over on the side of the road. Constable Pham and Mr. Preston left their vehicles. Mr. Preston pulled a rifle out of the back of his car. The rifle was registered to Ms. Preston. Mr. Preston killed Constable Pham and attempted to shoot Constable Pham's partner. The partner shot Mr. Preston, who died several days later.

The Coroner made comments to explain the recommendations. He noted that there was limited firearms training where the target is moving side to side, or the officer is running or trying to maintain cover. There was also limited training to simulate the effects of rapid breathing and rapid heart rate. The Coroner also noted that members of Mr. Preston's family testified that they were aware of the abuse for some time but did not think to act on it and report to police.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

- a. Ontario Provincial Police (OPP):
  1. Review current firearms training with a view to include an instinctive shooting component.

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<sup>472</sup> "Jury Recommendations," Inquest into the Deaths of Vu Duy Pham and Frederick Preston, Office of the Chief Coroner, Ontario, 2012

2. Ensure that the OPP Domestic Violence Occurrence Policy 2.14 is redrafted to explicitly include threats to third parties within the definition of a “domestic violence occurrence” and ensure that communications operators are familiarized with the categorization of incoming domestic violence calls in accordance with this policy. This policy will include a firearms check on a spouse.
  3. Ensure that the Communications/Dispatch Checklist for Domestic Violence is posted at each communications operator’s console.
  4. Ensure domestic violence risk factor training is incorporated into existing training for all communications operators and reviewed/signed off annually.
  5. Use existing training processes to incorporate the domestic homicide risk factors as assessed by the Domestic Violence Death Review Committee.
- b. Ministry of Community and Social Services (MCSS):
- Ensure domestic violence training is given to all full- and part-time staff at interval and transition houses in Ontario offering services to abused women.
  - Amend policy for at interval and transition houses in Ontario offering services to abused women to release information to police in any instance of a threat to an individual. This would include any family member of the client, spouse, shelter employees, friends, or any other groups associate with the clients.
  - All interval and transition houses in Ontario offering services to abused women are strongly encouraged to share best practices.
- c. Ontario Women’s Directorate
- Research and investigate barriers which prevent non-victim members from reporting domestic abuse within families.
  - Continue to support and fund public education about domestic violence risks, including Public Service Announcements (PSA) with the intent of directing persons at risk to appropriate sources of help. An example of PSAs would be the elder abuse pieces.
- d. Ministry of Community Safety and Correctional Services (MCSCS):
- Amend the Communications/Dispatch Checklist for Domestic Violence in order to ensure that current information regarding imminent risk factors from the Domestic Violence Death Review Committee (DVDRC) associated with domestic violence/domestic homicide are included.
- e. Ministry of Community and Social Services (MCSS):
- Adopt or develop a standardized risk assessment/structured interview for intake processes for all interval and transition houses in Ontario offering services to abused women.

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### **6.5.6. Inquest into the Deaths of Carol Culleton, Anastasia Kuzyk, and Natalie Warmerdam (Ontario, 2022)<sup>473</sup>**

This inquest examined the murders of three women in a rural area of Ontario by a man who had had relationships with all his victims. He had a lengthy history of intimate partner violence and other offences. The perpetrator, Basil Borutski, was born in Round Lake, Ontario. According to

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<sup>473</sup> “Jury Recommendations: Inquest into the Deaths of Carol Culleton, Anastasia Kuzyk, and Natalie Warmerdam.” Office of the Chief Coroner, Ontario (2022), not available online.

media reports,<sup>474</sup> exhibits filed at the inquest,<sup>475</sup> and court records,<sup>476</sup> he had been charged for more than twenty offences prior to the murders and convicted of roughly half. Most of these charges related to intimate partner violence with five different women. He was 57 years old at the time of the murders. His history of offences included the following:

- He was convicted of theft in 1974.
- He had a relationship that ended when he was twenty years old in 1977, when he began hitting his partner and was charged with assault causing bodily harm.
- From approximately 1995 to 2010, Mr. Borutski was married. Over the course of the marriage, he was charged with numerous IPV-related offences. The charges were all withdrawn, dismissed, or stayed, except for one conviction of assault, which he successfully appealed. The marriage ended in 2010. Following the divorce, there was a dispute over a purported marriage contract. The judge noted the evidence of Mr. Borutski's ex-wife and their children that Mr. Borutski was "violent, easily agitated and tyrannical toward his family members" and that Mr. Borutski had once tried to push his ex-wife out of a moving vehicle in front of the children, leading one of his children to call 911.
- In 2010, Mr. Borutski was convicted of refusing to provide a breath sample. His appeal was dismissed.
- A relationship with a server at the local tavern led to a 2010 charge of criminal harassment against him. That charge did not result in a conviction.

Following his divorce, Mr Borutski had a relationship with Natalie Warmerdam. She was a recently separated mother of two who lived on a hobby farm. During their three-year relationship, he began drinking heavily. He became controlling and isolated Ms. Warmerdam from her family and friends. He threatened her son and threatened to kill her animals; she fled to London, Ontario. He was arrested for these threats and while in custody, urinated on the cell floors and spat on a court guard and a police officer. In 2012, Ms. Warmerdam went to police, who charged Mr. Borutski with assault. Ms. Warmerdam did not wish to testify regarding his assaults on her. In December 2012, Mr. Borutski was convicted of assaulting a police officer, two counts of uttering threats, mischief, and breaching a peace bond in connection with these events. He was sentenced to 150 days in jail and two years' probation, with a ten-year weapons prohibition; because he had been in custody for 117 days prior to his conviction, he served 33 days of the sentence. He was ordered to attend the Partner Abuse Response (PAR) Program, among other conditions. Ms. Warmerdam feared Mr. Borutski and rented a panic button. She also kept a shotgun under her bed.

After his 2012 convictions, Mr. Borutski was assessed as lowrisk to reoffend, although in 2013, he was reassessed as being medium risk. All three of his IPV victims had reported that he became violent when drinking. After his release from prison, he moved closer to Ms. Warmerdam, causing

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<sup>474</sup> K. Nease, "Basil Borutski guilty of murdering 3 women in shocking killing rampage", *CBC News*, November 24, 2017, <https://www.cbc.ca/news/canada/ottawa/basil-borutski-trial-triple-murder-verdict-1.4407526>; S. Boesveld, "The Renfrew County Murders Are Not An Anomaly," *Chatelaine*, November 28, 2017, <https://www.chatelaine.com/living/features-living/basil-borutski-murders-renfrew-county/>.

<sup>475</sup> Untitled Power Point presentation by retired OPP Inspector Mark Zulinski, case manager for the prosecution during Mr. Borutski's trial (Exhibit #2); "Eastern Region Correctional Services Death Review Committee Report: Basil Borutski," (Exhibit #9) (October 28, 2015), not available online.

<sup>476</sup> *R v Basil Borutski*, 2017 ONSC 7762; *Borutski v Borutski*, 2011 ONSC 7099; *R v Borutski*, 2011 ONSC 3536.

concern among probation officials and others, but the sentencing judge did not require him to relocate. He was referred to the PAR program but was charged with new offences before it began.

In December 2013, Mr. Borutski started a relationship with Anastasia Kusiuk, a real estate agent whom he had dated several years before. He was helping to fix her house up to prepare it for sale. That month, he experienced financial stressors and began drinking heavily. He assaulted Ms. Kusiuk over the course of several hours, to the point where she begged him to kill her. He tried to strangle her. She suffered a concussion, two black eyes, and other injuries. She told family members that the bruises were caused by a motor vehicle accident. After the assault, Mr. Borutski was upset that Ms. Kusiuk did not want to have sex with him and burned childhood items of hers that held sentimental value. She gave him a month to leave and in January 2014, locked him out of the house while he was outside. The following day, her car, cell phone, food, and wallet were all gone. She reported to police that Mr. Borutski had kicked in the door and taken her mother's car. She also told police that Mr. Borutski told her he was dreaming of choking and drowning his former partners.

Mr. Borutski was convicted in September 2014 of choking Ms. Kusiuk, assault, mischief to property, failure to comply with his probation order, motor vehicle theft, driving while prohibited, and possession of a weapon (a crossbow) contrary to his probation order. He had served 350 days of pre-sentence custody and was sentenced to a further 160 days in prison and two years' probation and a lifetime weapons prohibition. He refused to sign the probation order.

Mr. Borutski completed his sentence and was released in December 2014. He was assessed as being at high risk to reoffend. He denied and minimized his conduct or blamed his victims for his actions. He was assessed as intimidating and controlling, with problems with compliance and anger. He was referred to the PAR program again but failed to participate. Over the course of the next several months, he repeatedly made excuses for failing to connect with or attend the PAR program. No steps were taken to address this breach of his conditions.

Mr. Borutski attempted to renew a brief relationship he had had with Carol Culleton, a Government of Canada employee. He started projects at her cottage without her permission, came to her home without permission, and blocked her car from leaving the driveway. He was jealous and controlling of her and angered by her refusal of his advances. Ms. Culleton expressed concern to her friends about texts she was receiving from Mr. Borutski.

On September 20, 2015, Ms. Culleton told Mr. Borutski to stop texting her because she was seeing another man. He replied by saying she was cruel and vindictive. He claimed she owed him money for the work he had done on her cottage. He also said, "karma will pay you for your heartless ways." The following day, while Ms. Culleton was not at her cottage, he ripped out flower beds he had planted, pulled a railing off her deck, and put menacing signs up around her property. That night, Ms. Culleton kept her phone by her bed in case she had to call 911. That same evening, Mr. Borutski told a neighbour that he was depressed and had found his girlfriend in bed with another man. He told the neighbour that he could kill his ex-wife and still go to heaven and that it was okay to murder but not to kill.

The next day, September 22, 2015, Mr. Borutski drove in a borrowed car to Ms. Culleton's cottage, broke in, and strangled her. He left the borrowed car and drove away in Ms. Culleton's car. There were no witnesses. Mr. Borutski then drove to Ms. Kusiuk's home and shot her with a shotgun, which he later told police he had found in an old motor home in a scrapyard. Ms. Kusiuk's sister escaped and called 911 from a road worker's truck at 8:52 AM. Mr. Borutski drove away. Officers

were dispatched to respond to an active shooter.<sup>477</sup> The first officer arrived at Ms. Kuzyk's home eight minutes later. The report was assigned as a critical incident, and the Ontario Provincial Police (OPP) Tactical Response Unit, as well as Emergency Response Team (ERT) members who were in training in Algonquin Park, were called in. Superintendent Derek Needham of the OPP was in charge of the OPP response at the scene. Following the 911 call from Ms. Kuzyk's sister, Supt. Needham drove toward Ms. Kuzyk's home and arranged for officers to set up a perimeter around Ms. Kuzyk's home, as the information he had been given suggested that Mr. Borutski was still in the house. Supt. Needham had not been informed about Mr. Borutski's history of intimate partner violence, although some of that information had been provided to the 911 dispatcher, and Mr. Borutski's name in the police database was flagged for family violence, alcohol, mental illness, and hating police. At the inquest, Supt. Needham testified that although he was based in Perth, more than 100 kilometres from Ms. Kuzyk's home in Wilno, he was the closest on-call critical incident commander to the area. At 9:30 AM, officers entered the home and found Ms. Kuzyk's body.

While the officers were responding to the 911 call from Ms. Kuzyk's home, Mr. Borutski drove to Ms. Warmerdam's home. Her twenty-year-old son, Adrian Warmerdam, was home and watched Mr. Borutski chase her with a shotgun. Mr. Warmerdam escaped, following the safety plan his mother had developed whereby she and her children would run in different directions if Mr. Borutski came to the home. Mr. Borutski shot and killed Ms. Warmerdam. Mr. Warmerdam called 911 at 9:19 AM, saying that his mother was being chased by Basil Borutski, who had a shotgun and that he had heard a single gunshot. Mr. Warmerdam remained in the woods for over an hour, on the phone with the dispatcher, until ERT members found him and escorted him to safety. The officers remained outside Ms. Warmerdam's home.

Officers at this point had learned of Mr. Borutski's history from a colleague. They drafted a list of potential targets to contact and took one of Mr. Borutski's former partners to a detachment. They also sent out media alerts and used social media to advise the public that a shooter was believed to be on the loose and to stay inside. Local schools were locked down, as well as the Pembroke Courthouse, Crown Attorney's office, and the local OPP detachment. Supt. Needham testified that they would have used the Ready Alert cell phone warning system had it been in place at the time.

At 11:09 AM, a real estate agent who was to meet Ms. Culleton called 911 to report finding Ms. Culleton's body. Emergency Medical Services (EMS) members arrived at 11:26 AM. The glass was broken in the front door. Police officers arrived at 11:50 AM and entered the home, where they found Ms. Culleton's body. The officers also found the car Mr. Borutski had driven there, with his wallet inside, and saw that the car registered to Ms. Culleton was not there.

At 12:00 PM, the officers at Ms. Warmerdam's property entered her home and found her body. During the inquest, officers testified that their entrance was delayed in part because they did not know if Mr. Borutski was still in the home and needed to contain the residence and because they prioritized finding Adrian Warmerdam. Also at noon, they received a "ping" from Mr. Borutski's

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<sup>477</sup> The information in this section is taken from the exhibits filed at the inquest, as well as the following media reports: Canadian Press, "Inquest hears details about police response to 2015 triple homicide in Ottawa Valley," *Global News*, June 15, 2022, <https://globalnews.ca/news/8922224/borutski-inquest-opp-response/>; M. Hayes, "OPP officers testify on role of police communication at inquest into 2015 triple-femicide case", *Globe and Mail*, June 16, 2022, <https://www.theglobeandmail.com/canada/article-opp-provide-testimony-at-inquest-into-2015-triple-murders/>, and G. Queneville, "OPP questioned about potential of warning victim on day of triple homicide," *CBC News*, June 16, 2022, <https://www.cbc.ca/news/canada/ottawa/coroners-inquest-intimate-partner-violence-renfrew-county-1.6489211>.

cell phone in the Pembroke area and dispatched officers to that area. At 12:28 PM, police received a tip that Mr. Borutski might be in a rural western part of Ottawa. His cell phone pinged in the area. Ottawa Police were notified and deployed ERT and set up a command post. A helicopter was dispatched, along with Tactical Response Unit members. A local school was locked down.

At 2:11 PM, the helicopter spotted Mr. Borutski in a field. An Ottawa police negotiator communicated with Mr. Borutski by text. During the text exchange, Mr. Borutski said he was innocent of every charge against him and that “the guilty have paid.” He was eventually arrested. Officers were not aware of Ms. Culleton’s interactions with Mr. Borutski and testified that they would have contacted to warn her about him if they had. There was also evidence that Mr. Borutski had made mental health calls, but the police were not aware of that. Police radios during the response were “glitchy,” and some specialized resources required during the hunt for Mr. Borutski were located an hour away. An officer also raised concerns about whether warning other potential victims after an intimate partner homicide would breach the privacy of victims.

After his arrest, Mr. Borutski gave a lengthy statement to police in which he said that after killing the three women, he intended to kill a man against whom he had had a grievance several years before. Mr. Borutski went to the sawmill where the man worked but was unable to find him and abandoned the plan. He had also planned to kill two OPP officers.

Mr. Borutski was convicted by a jury of two counts of first-degree murder, in the deaths of Ms. Kuzyk and Ms. Warmerdam, and of one count of second-degree murder, in the death of Ms. Cullen. He was sentenced to three consecutive life sentences with a total parole ineligibility of 70 years. He did not participate in the trial process.

In his reasons for sentence, Justice Robert Maranger of the Ontario Superior Court of Justice noted particularly the effect of the murders on Ms. Kuzyk’s sister and Ms. Warmerdam’s son, who will for the rest of their lives have to carry the images of the murders of their loved ones. He also commented on the toll that the murders took on the rural community of Renfrew County. He quoted from the Community Impact Statement filed in the proceedings, as follows:

Residents throughout east region and Renfrew County tell us they’ll never forget the lines of police cars on their rural roads. The fears they had for their safety and the safety of the families as schools and businesses were put on lockdown. They tell us how they no longer feel safe walking on their rural roads or hiking in the bush in Renfrew.

In Renfrew County during hunting season, the sound of gunshots is part of our culture, a normal everyday occurrence. However, since the murders, gunshots are triggering memories, and the sight of police vehicles, once a symbol of safety and security for many, are now a reminder of these horrific murders and fears of future violence.

Historically, folks in Renfrew County leave doors unlocked because everyone knows everyone else or is related to them and feels safe. Since the murders, for the first time, many community members are locking their homes. There are feelings of vulnerability and despair.<sup>478</sup>

In the years before the murder, Mr. Borutski showed significant anti-authority and anti-social attitudes. He made many complaints against police officers in Renfrew County and erected a sign on his property naming officers with whom he had had conflicts. He also kept written records and

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<sup>478</sup> [R v Basil Borutski](#), 2017 ONSC 7762, pp. 5–6 per Maranger J.

audio recordings relating to interactions he had with people who angered him. He reported being abused by his mother when he was a child.

The 2015 Correctional Services Death Review Committee Report, written by two Correctional Services Area Managers, noted that the area serviced by the two probation officers charged with monitoring him was very rural and vast. There were limited services in the area, limited employment opportunities, and the PAR program was a long distance from Mr. Borutski's homes. Probation required him to report twice monthly, in person, in recognition of his high-risk status. Probation also contacted Mr. Borutski's family doctor to get insight into his substance use issues and potential mental health issues. The office also contacted the victims and Mr. Borutski's ex-wife, but the office did not follow up to ask how they were managing. They did inform Ms. Warmerdam and Ms. Kuzyk of his release. Mr. Borutski was also the subject of several local High Risk Review Meetings involving the Crown and Victim Witness Assistance Program to put plans in place to address his potential risk. However, the connection between Mr. Borutski's consumption of alcohol and his violence was not properly assessed, and he was not referred to any substance abuse programs. There was no rationale in the records as to why Mr. Borutski's failure to attend the PAR program did not result in breach charges.

The inquest report stated the following:

In retrospect, it appears that the client was struggling with substance abuse, had deeply entrenched criminal orientation and anti-social qualities, and to look very deep, there are subtle indications of deviance that may have been made more clear with additional collateral information from personal sources and police. It would also appear that a fairly clear picture of an offence cycle could be identified with additional monitoring and use of these collateral contacts. A challenge with multiple stressors greatly increased the probability of violent acting out by this offender. It is difficult to identify specific stressors that were building in the client's life, as numerous factors existed. As more information became known about the offender and when everything is considered in its entirety, such as the extreme number of withdrawn or stayed charges for violent related offences, the escalating pattern of domestic violence, his efforts to deny any wrong doing and minimize his own responsibility, along with his continued blaming of the victims and his clear disdain for the Criminal Justice System and his attempts to manipulate, it would have been reasonable to have him considered as a potential Intensive Supervision Offender.<sup>479</sup>

The Coroner's Inquest took place in June 2022 (after a delay caused by Mr. Borutski's criminal proceedings and a further delay relating to the COVID-19 pandemic). It heard evidence over three weeks. The jury made 86 recommendations.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission:**

The Government of Ontario should:

1. Formally declare intimate partner violence as an epidemic.
2. Establish an independent Intimate Partner Violence Commission dedicated to eradicating intimate partner violence (IPV) and acting as a voice that speaks on behalf of survivors and victims' families, raising public awareness, and ensuring the transparency and accountability of government and other organizations in addressing IPV in all its forms. The Commissioner should have sufficient authority to ensure meaningful access to any person, document or

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<sup>479</sup> "Eastern Region Correctional Services Death Review Committee Report: Basil Borutski" (October 28, 2015) (Exhibit #9), p. 9.

information required to accomplish the Commission's mandate. The Commission should be provided with adequate and stable funding to ensure effectiveness.

3. Engage in meaningful consultation with IPV stakeholders and experts in the field to determine the mandate and responsibilities of the IPV Commission, which may include:
  - a. Driving change towards the goal of eradicating IPV in Ontario;
  - b. Evaluating the effectiveness of existing IPV programs and strategies, including the adequacy of existing funding;
  - c. Analyzing and reporting on all IPV-related issues with a view to improving awareness of IPV issues and potential solutions;
  - d. Advocating for survivors and their families, having regard to addressing the systemic concerns of survivors navigating the legal system.

Consideration should be given to the United Kingdom's Domestic Abuse Commissioner model in developing the mandate of the Commission.

4. Create the role of a Survivor Advocate to advocate on behalf of survivors regarding their experience in the justice system.
5. Immediately institute a provincial implementation committee dedicated to ensuring that the recommendations from this Inquest are comprehensively considered and any responses are fully reported and published. The committee should include senior members of relevant ministries central to IPV and an equal number of community IPV experts. It should be chaired by an independent IPV expert who could speak freely on progress made on implementation.
6. Amend the Coroners Act to require the recipient of an inquest recommendation to advise the Office of the Chief Coroner if a recommendation is complied with or to provide an explanation if it is not implemented.
7. Ensure that IPV issues are addressed using an all-of-government approach across ministries and cooperate and coordinate with federal, provincial, and territorial partners in seeking to end IPV.
8. Require that all justice system participants who work with IPV survivors and perpetrators are trained and engage in a trauma-informed approach to interacting and dealing with survivors and perpetrators.
9. Explore incorporating restorative justice and community-based approaches in dealing with appropriate IPV cases to ensure safety and best outcomes for survivors.
10. Encourage that IPV be integrated into every municipality's community safety and well-being plan.
11. Study the feasibility of and implement, if feasible, justice sector participants having access to relevant findings made in family and civil law proceedings for use in criminal proceedings, including at bail and sentencing stages. The study would, in part, inquire into the following:
  - a. The process to identify relevant findings and for sharing those findings with other justice participants;
  - b. Which justice participants should have access to the findings made by a civil or family court;
  - c. What documents from civil and family law proceedings should be shared with justice sector participants and how to facilitate sharing of such documents;
  - d. What permissible uses could be made of the documents and findings in a criminal proceeding;
  - e. Models in other jurisdictions that identify relevant IPV cases in different courts.

12. Ensure that survivors and those assisting survivors have direct and timely communication with probation officers to assist in safety planning.
13. Require all police services to immediately inform the Chief Firearms Officer (CFO) of IPV-related charges after they are laid and provide any relevant records, including Firearms Interest Police information.
14. Create a “Universal RMS” records management system accessible by all police services (including federal, provincial, municipal, military, and First Nations) in Ontario, with appropriate read/write access to all IPV stakeholders, including Probation, CFO, Crown’s offices, Ontario Court of Justice, Superior Court of Justice, correctional institutions, and parole boards. Police services that wish to use their own RMS are to update IPV information in the Universal RMS.
15. Require primary actors involved in a major incident to conduct a formal debrief and write a report identifying lessons learned and recommendations for improvement, if appropriate.
16. Review policies to ensure the timely, reliable, consistent, and accurate dissemination of information, including the use of emergency alerts and media releases, where the police are aware of circumstances that could put the public in danger and that the focus is on safety when developing policies regarding what information to share with whom and when. Consideration should be given to disseminating information through alternative methods where cellular service is not consistently available.
17. Establish clear guidelines regarding the flagging of perpetrators or potential IPV victims in police databases, immediate dispatch and police access to the identities and contact information of potential targets, and how to notify those targets.
18. Recognize that the implementation of the recommendations from this Inquest, including the need for adequate and stable funding for all organizations providing IPV support services, will require a significant financial investment and commit to provide such funding.
19. Create an emergency fund, such as the “She C.A.N Fund” in honour of Carol Culleton, Anastasia Kuzyk, and Nathalie Warmerdam, to support women living with IPV who are taking steps to seek safety. This fund should include the following:
  - a. Easy, low-barrier access for IPV survivors seeking to improve their safety;
  - b. Referral to the fund through IPV service providers;
  - c. Small grants of up to \$7000;
  - d. It should have no impact on Ontario Works or Ontario Disability Support Plan payments;
  - e. Consideration for the needs of rural and geographically remote survivors of IPV;
  - f. Funding to be provided on an annualized basis, with adequacy assessed and considered after the first three years;
  - g. Inject a significant one-time investment into IPV related support services.
20. Realign the approach to public funding provided to IPV service providers with a view to removing unnecessary reporting obligations with a focus on service. Draw on best practices in Canada and internationally, and adopt and implement improved, adequate, stable, and recurring funding that incorporates the following:
  - a. IPV services are core programming and should receive annualized funding like other public services;
  - b. Service providers provide one annual report for all funders across government to account for the funds received, articulate results, and highlight key challenges, learnings, and accomplishments;

- c. Recognition that, in remote and rural areas, funding cannot be the per-capita equivalent to funding in urban settings, as this does not take into account rural realities, including that:
    - i. IPV is more prominent in rural areas;
    - ii. Economies of scale for urban settings supporting larger numbers of survivors;
    - iii. The need to travel to access and provide services where telephone and internet coverage is not available;
    - iv. The lack of public transit;
    - v. The cost of transportation for survivors and service providers.
  - d. Consideration of the remoteness quotient used to calculate funding in other social services, such as education and policing;
  - e. Enhanced funding for IPV service providers, including shelters, sexual assault support centres, victim services, and counselling services, considering urban and rural realities;
  - f. Designated funding for transportation for those receiving IPV-related support services where public transportation is inadequate or unavailable, such as in Renfrew County,
  - g. Funding to ensure mental health supports for IPV service providers, as well as timely access to trauma supports immediately following a traumatic event;
  - h. Funding for services provided to survivors that allows for the hiring and retention of skilled and experienced staff so that they are not required to rely on volunteers and fundraisers in order to provide services to survivors;
  - i. Funding for mobile tracking system alarms and other security supports for survivors of IPV;
  - j. Funding for counselling for IPV survivors;
  - k. Funding for services dedicated to perpetrators of IPV.
21. Develop a plan for enhanced second-stage housing for IPV survivors.
  22. Fund for “safe rooms” to be installed in survivors’ homes in high-risk cases.
  23. Develop and implement a new approach to public education campaigns to promote awareness about IPV, including finding opportunities to reach a wider audience in rural communities. These messages should promote broad recognition of how to seek support, risk factors, and warning signs of IPV, community and bystander engagement, be accessible in multiple languages and in multiple formats, and ensure that rural residents can identify themselves in the messaging and materials.
  24. Complete a yearly annual review of public attitudes through public opinion research and revise and strengthen public education material based on these reviews, feedback from communities and experts, international best practices, and recommendations from the Domestic Violence Death Review Committee (DVDRC) and other IPV experts.
  25. Use and build on existing age-appropriate education programs for primary and secondary schools, universities, and colleges. Such programs should include: violence prevention, recognizing healthy and abusive relationships, identifying subtle indicators of coercive control, understanding risk factors (such as stalking, fear caused by IPV, strangulation, threats to kill), managing and processing feelings, dispute resolution, community and bystander obligations, the need for safety planning and risk management, and the unique experiences in rural and urban settings.

26. Ensure teachers are trained to deliver the IPV-related curriculum and utilize IPV professionals regularly to provide support for the delivery of primary, secondary, and post-secondary programming.
27. Develop a roster of resources available to support classroom teachers in the delivery of primary, secondary, and post-secondary programming where local IPV professionals are not available.
28. Review existing training for justice system personnel who are within the purview of the provincial government or police services.
29. Provide professional education and training for justice system personnel on IPV-related issues, which should include:
  - a. Annual refresher courses;
  - b. Risk assessment training with the most up-to-date research on tools and risk factors;
  - c. Trauma-informed practices, including an understanding of why survivors may recant or may not cooperate with a criminal investigation, best practices for managing this reality, and investigation and prosecution of perpetrators;
  - d. Crisis management training;
  - e. The availability and use of weapons prohibition orders in IPV cases;
  - f. Meaningful screening of sureties;
  - g. Greater use of court-ordered language ensuring alleged and convicted offenders will not reside in homes that have firearms;
  - h. Indicators of IPV including coercive control, and awareness of risk factors for lethality (including destruction of property, especially by fire, harm to pets, strangulation, criminal harassment, stalking, sexual violence, and threatening police);
  - i. Unique rural factors;
  - j. Firearm risks, including the links between firearm ownership and IPV;
  - k. Opportunities for communities, friends, and families to play a role in the prevention and reporting of IPV.
30. Provide specialized and enhanced training of police officers with a goal of developing an IPV specialist in each police detachment.
31. Track whether mandated IPV-related professional education and training is completed by all justice system personnel.
32. Establish a province-wide 24/7 hotline for men who need support to prevent them from engaging in IPV.
33. Provide services aimed at addressing perpetrators of IPV that should include:
  - a. An approach that is not one-size-fits-all;
  - b. A variety of group-based interventions augmented with individual counseling and case management sessions to assess and manage risk and to supplement services, as needed, to address individual needs;
  - c. Peer support and appropriate circles of support;
  - d. Prioritizing the development of cross-agency and cross-system collaborative services;
  - e. Service models in the areas of substance use and abuse, general criminal behaviour, mental health, fathering, and culturally specific services;

- f. The ability to respond immediately with risk management services in collaboration with IPV service providers;
  - g. Being accessible by clients voluntarily and via referral, not just through the criminal justice system;
  - h. Programs are funded at a level that anticipates an increased stream of referrals;
  - i. Make in-custody IPV programs available in the community as well so that offenders can complete programs started in custody;
  - j. Audits of PARs and other perpetrator intervention programs for efficacy, consistency, and currency;
  - k. Increasing program availability and develop flexible options for IPV perpetrators on remand, serving sentences, and in the community.
34. Recognize the specialized knowledge and expertise of IPV service providers involved in perpetrator intervention and support the development of workforce capacity within the sector by developing and providing competency-based training opportunities. Service contracts should include funding for supervision, ongoing professional development, and mental health support.
  35. Address barriers and create opportunities and pathways to services for IPV perpetrators that can be accessed in the community. Referrals to service providers should be made as early as possible and should be repeatedly and persistently offered to both engage perpetrators and reinforce the need for perpetrators to be accountable for their abusive behaviours.
  36. Improve the coordination of services addressing substance use, mental health, child protection, and IPV perpetration, and encourage cross-agency service provision and case management.
  37. As new services are funded, include aims and outcomes associated with building an underlying network of specialized services to address IPV perpetration and developing messaging around its availability.
  38. Ensure that IPV-related public education campaigns address IPV perpetration and include men's voices, represent men's experiences, and prompt men to seek help to address their own abusive behaviours. They should highlight opening the door to conversations about concerning behaviours.
  39. Endeavour to minimize destabilizing factors for perpetrators of IPV that increase risk, correlates of IPV, and barriers for survivors to leave violence. Specific consideration should be given to financial instability, housing insecurity, and mental health issues, including addictions treatment options, and how these factors and potential solutions are affected by rural contexts.
  40. Explore amending the Family Law Act, following meaningful consultation with stakeholders, including survivors and IPV service providers, to provide authority to order counselling for the perpetrator where IPV findings are made by the family court.
  41. Investigate and develop a common framework for risk assessment in IPV cases, which includes a common understanding of IPV risk factors and lethality. This should be done in meaningful consultation and collaboration with those impacted by and assisting survivors of IPV and consider key IPV principles, including victim-centred, intersectional, gender-specific, trauma-informed, anti-oppressive, and evidence-based approaches.
  42. Co-train justice system personnel and IPV service providers on the risk assessment framework and tools so that there is a common understanding of the framework and tools for those who support or deal with survivors.

43. Ensure that survivor-informed risk assessments are incorporated into the decisions and positions taken by Crown relating to bail, pleas, sentencing, and eligibility for early Intervention Programs.
44. Clarify and enhance the use of high-risk committees by:
  - a. Strengthening provincial guidelines by identifying high-risk cases that should be referred to committee;
  - b. Identifying and including local IPV service providers that are in a position to assist with case identification, safety planning, and risk management. Consideration should be given to including IPV service providers supporting perpetrators;
  - c. Ensuring that involved IPV service providers at high-risk committees are given the necessary information to facilitate their active participation, subject to victim consent where applicable.
45. Establish policies making clear that, absent exceptional circumstances, those assessed as high risk or where the allegations involve strangulation should not qualify for early intervention. Crowns should also consider a history of IPV whether or not convictions resulted when determining whether early intervention is appropriate.
46. Study the best approach for permitting disclosure of information about a perpetrator's history of IPV and the potential risk to new and future partners who request such information, with a view to developing and implementing legislation. In doing so, study Clare's Law in the United Kingdom and similar legislation in Saskatchewan, Alberta, and Manitoba, Bill 274 (Intimate Partner Violence Disclosure Act 2021), and any other relevant legislation and policy. In the interim, develop a draft policy that can address this issue.
47. Set up IPV Registry for repeat IPV offenders, similar to the Sex Offender Information Registry Act registry.
48. Explore the implementation of electronic monitoring to enable the tracking of those charged or found guilty of an IPV-related offence and enable the notification of authorities and survivors if the individual enters a prohibited area relating to a survivor. In determining the appropriateness of such a tool in Ontario, monitor the development of programs utilizing such technology in other provinces, with specific consideration given to:
  - a. Coverage of cellular networks, particularly in remote and rural regions;
  - b. Storage rules and protocols for tracking data;
  - c. Appropriate perpetrator programs and supports needed to accompany electronic monitoring;
  - d. Whether the tool exacerbates risk factors and contributes to recidivism;
  - e. Understanding any impacts after an order for such technology expires;
  - f. Frequency and impact of false alarms;
  - g. The appropriateness of essential services being provided by private, for-profit partners.
49. Start grassroots "Safe Spaces" program that businesses can participate in where survivors can feel safe and ask for information (i.e., pamphlets and handouts from women's shelters, VWAP and men's programs).
50. In referrals made by the OPP to Victim Services, ensure adequate information is provided, including relevant history, safety concerns, and known risk factors.
51. Ensure that the OPP conduct a study on improving tactical response timelines as it applies to rural environments generally and in IPV cases in particular.

52. Expand cell service and high-speed internet in rural and remote areas of Ontario to improve safety and access to services.
53. Set up satellite offices for police officers to work safely and comfortably to spread police resources more evenly over wide rural areas (i.e., consider asking schools and municipal governments to provide office space).
54. Enhance court supports for IPV survivors and develop an IPV-focused model for criminal courts similar to the Family Court Support Worker Program. Consideration should be given to the independent legal advice program for survivors of sexual violence as a model for IPV survivors.
55. Encourage Crowns to consult with the Regional Designated High-Risk Offender Crown for any case of IPV involving a high-risk offender that may meet the criteria for Dangerous or Long-term Offender designations.
56. Crowns should actively oppose variation requests to have firearms returned for any purpose, such as hunting.
57. Strengthen annual education for Crowns regarding applications for Dangerous and Long-term Offender designations in high-risk IPV cases.
58. Commission a comprehensive, independent, and evidence-based review of the mandatory charging framework employed in Ontario, with a view to assessing its effect on IPV rates and recidivism, with particular attention to any unintended negative consequences.
59. Conduct study of judges' decisions in IPV cases and track in longitudinal studies for recidivism, violence escalation, and future victims.
60. Review and amend, where appropriate, standard language templates for bail and probation conditions in IPV cases and develop a framework for identifying the appropriate conditions based on level of risk in collaboration with stakeholders, including judges, justices of the peace, police, probation, crown attorneys, the CFO, and community providers with subject matter expertise in IPV risk management. The following factors should be considered:
  - a. Enforceability;
  - b. Plan for removal or surrender of firearms and the Possession and Acquisition License (PAL);
  - c. Residence distance from victims;
  - d. Keeping probation aware;
  - e. Safety of current and previous victims;
  - f. Possibility of a "firearm-free home" condition;
  - g. Past disregard for conditions as a risk factor.
61. Require that primary actors advise the CFO in a timely manner of expected and changed residential addresses of individuals who have been placed under weapons conditions.
62. When evaluating the suitability of a prospective surety in IPV cases, Crowns should make inquiries as to whether residential sureties have firearms in their home or a PAL.
63. Develop a process, in consultation with the judiciary, to confirm that release conditions are properly documented.
64. Ensure that Probation Services reviews and, if necessary, develops standardized protocols and policies for probation officers with respect to intake of IPV offenders and with respect to victim safety.
65. Review the mandate of Probation Services to prioritize:

- a. Condition compliance;
- b. Victim safety;
- c. Offender rehabilitation.

66. Require that probation officers, in a timely manner, ensure:

- a. Probation conditions are appropriate for the level of risk of the client and written in a way they can enforce and, if not, request a variation;
- b. They contact the survivor to inform her of the offender's living situation, any conditions or limitations on his movement or activities, and what she should do in the event of a possible breach by the offender;
- c. Regular contact with survivors to receive updates, provide information regarding the offender's residence and locations frequented, and any changes to such circumstances, and seek input from survivors and justice system personnel before making decisions that may impact her safety;
- d. Improved supervision of high-risk perpetrators released on probation, including informed decision-making when applying or seeking to modify conditions that impact the survivor's needs and safety;
- e. Risk assessments and risks of lethality are taken into account when making enforcement decisions.

67. Ensure existing policy and guidelines require probation officers to follow through on enforcement of non-compliance by requiring delivery and documentation of clear instructions regarding expectations to supervised offenders in a way that allows for direct and progressive enforcement decisions. This should be a focus for performance management and quality assurance processes.

68. Ensure collaboration between corrections and probation staff to improve rehabilitation and risk management services. Consideration should be given to two-way information-sharing, including of case notes, and opportunities to order treatment in institutions for those with existing probation orders who are on remand.

The Chief Firearms Officer should work with appropriate decision-makers to:

69. Review the mandate and approach of the CFO's Spousal Support line to:

- a. Change its name to one that better reflects its purpose. It should be clear that it is broadly accessible and not limited to a particular kind of relationship;
- b. Be staffed 24 hours a day and 7 days a week;
- c. Be publicized to enhance public awareness and become better known among policing partners possibly through All Chiefs' bulletins.

70. Create guidelines for staff in making decisions regarding whether to issue, review, revoke, or add conditions to PALs to ensure consistency among staff and through time. Particular attention should be paid to red flags and risk factors around IPV, including where there is no conviction.

71. Require that a PAL is automatically reviewed when someone is charged with an IPV-related offence.

72. Require PAL applicants and holders to report to the CFO in a timely manner any change in information provided in application and renewal forms submitted to the CFO, including when an individual with weapons restrictions comes to reside in their home.

73. Amend PAL application and renewal forms to require identification as a surety.

The Office of the Chief Coroner should:

74. Ensure that the DVDRC reviews its mandate with a view to enhancing its impact on IPV and provide the DVDRC with improved supports.
75. Ensure DVDRC annual reports are published online in a timely manner.
76. Ensure that DVDRC reports and responses to recommendations are publicly available and will continue to be available without charge.
77. Consider adopting Femicide as one of the categories for manner of death.

The Information and Privacy Commissioner of Ontario should:

78. Together with the DVDRC, justice partners, and IPV service providers, develop a plain-language tool to empower IPV professionals to make informed decisions about privacy, confidentiality, and public safety.

The Government of Canada should:

79. Explore adding the term “Femicide” and its definition to the Criminal Code to be used where appropriate in the context of relevant crimes.
80. Consider amendments to the Dangerous Offender provisions of the Criminal Code or the inclusion of a new classification of Offender under the Criminal Code that better reflects the realities of IPV charges and takes into account risk factors for serious violence and lethality in an IPV context.
81. Undertake an analysis of the application of s. 264 of the Criminal Code with a view to evaluating whether the existing factors adequately capture the impact on survivors. Consider the removal of the subjective requirement that the action causes the victim to fear for their safety.
82. Consider finding alternate means for survivors to attend and testify in court, such as by video conferencing.
83. Implement the National Action Plan on Gender-based Violence in a timely manner.
84. Establish a Royal Commission to review and recommend changes to the Criminal Justice system to make it more victim-centric, more responsive to root causes of crime, and more adaptable as society evolves.
85. Include “coercive control” as defined in the Divorce Act as a criminal offence on its own or as a type of assault under s. 265 of the Criminal Code.

The Parties to this Inquest should:

86. Reconvene one year following the Verdict to discuss the progress in implementing these recommendations.

## 6.6. Manitoba

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### 6.6.1. Fatality Inquest Respecting the Deaths of Doreen Leclair and Corrine McKeown (Provincial Court of Manitoba, 2002)<sup>480</sup>

Media reports indicate that Doreen Leclair and Corrine McKeown were two Métis sisters, both of whom were stabbed to death on February 16, 2000.<sup>481</sup> William Dunlop was later arrested and convicted for their murders.

According to media reports, the two women called the police and 911 emergency services five times over eight hours to get help on both February 15 and 16, 2000. The tapes of these 911 calls were released to the public. The first call was made just before 10 PM on February 15, 2000. The call was disconnected. When the operator called back, one of the women said someone had been shot. Police were dispatched to the address. Mr. Dunlop gave a fake name, calling himself Hank Wacko.<sup>482</sup> In the second call, the women were both instructed to phone the police directly. During the third call, the women reported that Ms. McKeown had been stabbed by a man violating a restraining order. The operator told them that they were partly to blame, and they should solve the problem themselves. During the fourth call, one woman could be heard saying, “Please help me.” The operator promised to send police, but the police were not dispatched. In the final call, there were faint sounds coming from one or both of the women. The operator hung up and dialed the house. Mr. Dunlop answered the phone and tried to convince the operator that everything was fine. The operator sent a car to the house. The women died from stab wounds before police arrived.

The fatality inquest before Judge Judith Webster of the Provincial Court of Manitoba was held to look at how 911 operators and police handled the 911 calls the women made before their deaths. The Report provided a singular umbrella recommendation regarding the handling of domestic violence calls at the Winnipeg Police Service (WPS) Communication Centre, as well as a number of other recommendations.

#### Recommendations Relevant to the Mandate of the Mass Casualty Commission<sup>483</sup>

1. That a comprehensive review be undertaken of the Communication Centre, including the topics and issues set forth in order to ensure proper and consistent job performance, particularly in the area of domestic violence calls.
2. Training (Initial): It is further recommended that the Training Division review the training syllabus of the Communication Centre to ensure that the information/procedures being taught are accurate, consistent, and relevant. It is also crucial that the training materials conform to the policies and procedures of the Winnipeg Police Service, especially the Family Violence

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<sup>480</sup> “Fatality Inquiries Act, Report by Provincial Judge on Inquest: Respecting the Deaths of Doreen Leclair and Corrine McKeown,” Judge Judith Webster for the Provincial Court of Manitoba (October 2002), [https://www.manitobacourts.mb.ca/site/assets/files/1051/911\\_report.pdf](https://www.manitobacourts.mb.ca/site/assets/files/1051/911_report.pdf).

<sup>481</sup> Few of the facts were set out in the inquest report. See “The Winnipeg 911 Murders” *CBC News* (2 July 2004), <https://cbc.ca/news2/background/aboriginals/winnipeg911.html>.

<sup>482</sup> K. Foss, “Winnipeg Inquest Hears 911 Tapes” *Globe and Mail* (11 December 2001), <https://theglobeandmail.com/news/national/winnipeg-inquest-hears-911-tapes/article4157762/>.

<sup>483</sup> The recommendations are not numbered in the Report.

Policy. Exceptions, if any, must be clearly identified. These materials should be updated on a regular basis.

3. Training (Ongoing): It is further recommended that the Training Division develop and implement mandatory refresher training courses for the staff of the Communication Centre, to be conducted on a regular and consistent basis.
4. It is further recommended that the Training Division coordinate a core group of mandatory training sessions that include but are not limited to such topics as:
  1. Current and applicable family/domestic violence prevention procedures;
  2. Aboriginal and cultural awareness;
  3. Court orders and police role in enforcement;
  4. Stress management;
  5. Disaster procedures;
  6. Suicide prevention; and
  7. Special unit training.
5. It is further recommended that additional training sessions are identified following consultation with the staff of the Communication Centre.
6. It is further recommended that part-time or casual staff attend all mandatory training sessions.
7. Workplace and External Influences (Morale): It is further recommended that a comprehensive review evaluate not only how major incidents such as February 15–16 affect staff but also the mutual obligation of the employees and the employer.
8. Workplace and External Influences (Public): It is recommended that as part of the comprehensive review, the Winnipeg Police Service develop and launch a public information and education campaign on the correct use of the 911 service and the 986-6222 line and to explain the dangers of false or frivolous calls.
9. It is further recommended that the review explore the use of charging those abusing the 911 service under the Criminal Code or municipal bylaw.
10. It is further recommended that the comprehensive review inquire into the feasibility or possibility of providing a 311 service that allows callers a quick-dial for non-emergency calls to the Police Service.
11. Police Response: It is recommended that as part of a comprehensive review the feasibility of having officers attending domestic violence calls, scroll the MDT [mobile data terminal] to ascertain the telephone subscriber at the location before performing other standard CPIC [Canadian Police Information Centre] checks.
12. Police Response: It is further recommended that as part of the comprehensive review, the impact of the policy that all domestic calls be priority 1 be considered in the context of police resources.
13. Policy and Procedure (Domestic Violence): As noted in the Training Recommendations, a core group of mandatory sessions should be developed and presented on current and applicable family/domestic violence prevention procedures, and court orders and police role in enforcement.
14. Policy and Procedure (Domestic Violence): It is further recommended that as part of a comprehensive review, reconsideration be given to the current policy that all domestic calls be Priority 1 (or higher).

15. Call Types: It is recommended that as part of the comprehensive review, all call types be analyzed and assessed for clarity and accuracy.
16. It is further recommended as part of the comprehensive review and with the involvement of the Training Division, that information and training about call types, particularly domestic calls and breaches of court orders, be provided to the Winnipeg Police Service at large.
17. It is further recommended that dissemination of call-type information be part of initial and ongoing training for all divisions in the Winnipeg Police Service.<sup>484</sup>
18. It is further recommended that as part of a comprehensive review, consideration be given as to whether policy is merely a guideline or something that must be followed by Communication Centre staff to the letter.
19. Family Violence Policy: It is recommended that as part of the comprehensive review, consideration be given that the Winnipeg Police Service, in consultation with the key stakeholders in government and in the community and with other Police Services, re-examine the Domestic Violence Policy in order to develop reasonable guidelines for assigning priorities for calls dealing with domestic violence.
20. It is further recommended that the comprehensive review examine the feasibility of the Winnipeg Police Service, together with the Department of Justice (Manitoba), other law enforcement agencies, and others involved in domestic violence issues, review the Domestic Violence Policy, in particular Zero Tolerance and the manner in which the policy relates to repeat offenders.
21. It is further recommended that serious consideration be given to a senior member of the Winnipeg Police Service, possibly a member of the Executive, become the Domestic Violence Coordinator for the Service, including the Communication Centre, to address staffing, training, and policy issues relative to Domestic Violence.
22. Technology (Equipment): It is further recommended that given the often ongoing nature of domestic violence and stalking, the review look into a system to enable the storage of calls and transcripts in excess of two years.

## 6.7. Alberta

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### 6.7.1. Public Fatality Inquiry: Brenda Mary Moreside (Minister of Justice and Solicitor General of Alberta, 2013)<sup>485</sup>

Brenda Moreside and Stan Willier were common law partners, living together in High Prairie, Alberta. In the early hours of February 13, 2005, Mr. Willier returned to the home. He did not have a key. He removed plastic that had been covering a broken window and climbed into the house. Ms. Moreside returned after Mr. Willier. Both were intoxicated. Ms. Moreside was upset that Mr. Willier was there and telephoned 911. A civilian operator in Edmonton took the call. Ms. Moreside said she did not want Mr. Willier arrested, as he would lose his job, but wanted him removed from

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<sup>484</sup> Emphasis in original.

<sup>485</sup> "Report to the Minister of Justice and Solicitor General: Public Fatality Inquiry for Brenda Mary Moreside," Fatalities Inquiries Act, Alberta (November 2013), <https://open.alberta.ca/dataset/f582985e-55bf-4f18-82d5-29171aa21181/resource/cf3f8f89-7f42-4da8-8a7c-ff297e0e3374/download/2015-fatality-report-brendamoreside.pdf>.

the home. That operator saw that there had been a report the previous year of difficulties between Ms. Moreside and Mr. Willier. She told Ms. Moreside that Mr. Willier was legally entitled to be in the home and could not be arrested for drunkenness in a private home. A few minutes later, the constable on duty called Ms. Moreside and spoke to her. Ms. Moreside asked for Mr. Willier to be taken to the “drunk tank.” The constable suggested that both she and Mr. Willier should get some sleep and deal with the situation in the morning.

Twelve days later, on February 25, 2005, Ms. Moreside’s body was found in the home. Mr. Moreside pleaded guilty to manslaughter and said Ms. Moreside had come at him with a knife, they struggled, and Ms. Moreside died from multiple stab wounds. They were both intoxicated.

The inquiry learned that Mr. Willier’s criminal record demonstrated that there was “much violence” in his past. The only incident involving Ms. Moreside was an incident the previous year, which did not result in charges. The fatality inquiry emphasized that there had been significant changes in training and practices related to domestic violence since Ms. Moreside’s death.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

1. Police services that utilize non-police telephone operators ensure that such operators are trained in their jobs, especially in respect of recognition of risk factors in domestic violence situations but in all personal risk situations.
2. Police services should institute programs of domestic violence, risk assessment, and management in their recruit training programs and continue those programs into all of their field offices with a systems setup to monitor continuing education by all field officers in respect of domestic violence risk situations and management of domestic violence situations and indeed all personal risk situations.
3. Programs should be set up in all police situations to monitor the performance of officers in their early stages of coming into fieldwork so as to ensure that those officers receive the necessary backup and guidance to allow them to develop their skills, especially in respect of domestic violence situations.
4. That police services on a national, regional, and local basis develop a domestic violence policy and thereafter advise the community and all necessary agencies of that policy and institute programs within their ranks to enforce such a policy.
5. That police services either through the Police Advisory Commission or through their own offices adopt a procedure whereby when a domestic violence situation arises, as defined by the existing domestic violence handbook, officers intervening in such a situation are required to complete for their files a document such as the FVIR (Family Violence Investigation Report) form and ensure that policy in respect of completion of such document is consistent within its ranks and that a review process of such reports be set up within their police services to ensure that when appropriate referrals are made to I-TRAC (Integrated Threat and Risk Assessment Centre)<sup>486</sup> for analysis and return assessments to the police services so that they might monitor risk concerns.

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<sup>486</sup> Alberta’s I-TRAC assists law enforcement and criminal justice agencies in the management of domestic violence and criminal harassment cases, among others. See ALERT Alberta Law Enforcement Response Teams, “Assessments on the Right TRAC” (15 May 2018), <https://alert-ab.ca/assessments-on-the-right-trac/>.

6. That governmental agencies ensure that institutions such as I-TRAC continue to be funded and functional and available to all levels of operations within the province where risk assessments are required.

## 6.8. New Brunswick

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### 6.8.1. Exploring the Links: Firearms, Family Violence and Animal Abuse in Rural Communities (New Brunswick and Prince Edward Island, 2008)<sup>487</sup>

The Canadian Firearms Centre, RCMP and Public Safety Canada funded this study, the main goal of which was to “examine, from a broad regional perspective, the various dimensions or forms in which firearms serve as instruments of control, intimidation, and abuse in family violence situations.”<sup>488</sup> The study was published in 2008.

The authors noted that despite the increase in research on intimate partner violence generally and despite statistics showing that a significant portion of victims of intimate partner homicide were killed by long guns in rural communities, there was a dearth of research on family violence in rural contexts. The study included surveys, a literature search, media analysis, and a case law review. The authors worked with transition houses in the two provinces, Victim Services programs, firearms officers, and other stakeholders to conduct their research. They used qualitative and quantitative methods, engaging in focus group discussions with women in transition houses in the two provinces as well as surveys of these women. They also conducted individual interviews with women and with service providers. They asked these participants about their experiences and their thoughts on what recommendations might improve the situation for women in rural communities with similar experiences. A total of 72 people participated in individual or focus group discussions, and 283 women responded to the surveys, which were conducted over the course of a year. A significant majority of the women responding to the survey lived in rural communities.

The authors used the terms “gun culture” and “hunting culture” in their Report. They emphasized that though there is commonality within a given culture, there is not uniformity. They acknowledged the risk of ascribing all aspects of a social situation to culture, noting the importance of other factors, such as a person’s agency. They also noted the importance of traditions that have been passed on for generations in shaping gun culture, although “tradition is not the only aspect of importance in gun culture.”<sup>489</sup>

The authors noted the following findings from earlier research:

1. Gun ownership varies in Canada. In Ontario, 14% of residents owned at least one gun, while the numbers were 36% in New Brunswick, 20% in Prince Edward Island, and 69% in the

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<sup>487</sup> “Exploring the Links: Firearms, Family Violence, and Animal Abuse in Rural Communities,” Final Research Report submitted to Canada Firearms Centre, Royal Canadian Mounted Police, and Public Safety Canada (May 2008), [http://www.legal-info-legale.nb.ca/en/uploads/file/pdfs/Family\\_Violence\\_Firearms\\_Animal\\_Abuse.pdf](http://www.legal-info-legale.nb.ca/en/uploads/file/pdfs/Family_Violence_Firearms_Animal_Abuse.pdf).

<sup>488</sup> “Exploring the Links,” p. 11.

<sup>489</sup> “Exploring the Links,” p. 7.

Territories. Approximately one quarter Canadians owned a firearm, compared with 48% in the United State.

2. New Brunswick had one of the highest firearms ownership rates among the provinces and one of the highest rates of firearms deaths from homicide, suicide, and accident.
3. A third of Canadian women killed by their partners are shot.
4. Nearly 70% of the homicides of women by their partners in New Brunswick occurred in small towns and rural communities, and almost half were killed by firearms.
5. Rural women in New Brunswick were more likely than urban women to experience low literacy, lack of education, marginal employment skills, and lack of access to training and educational opportunities. These factors, along with high rates of unemployment in rural New Brunswick, created significant barriers for women leaving abusive relationships. Additional barriers included geographic and social isolation and lack of access to transportation.
6. Community values in rural areas also encourage women to return to their abusers. The authors noted, "The constellation of economic and social factors in rural areas, in combination with the rapid decline in services and programs, may set the stage for potentially lethal outcomes for abused rural women."<sup>490</sup> They also referred to research showing the presence of a "strong conservative rural ethos that minimizes and normalizes male dominance and violence in the home, and tends to blame the victim for not being submissive or promoting harmony."<sup>491</sup>

The women surveyed by the authors provided the following information about violence generally:

1. 80% said that they had experienced two or more types of abuse.
2. 93% of the women had suffered emotional abuse.
3. Almost two thirds said that they had been physically abused.
4. Half had experienced financial abuse.
5. Just over 20% had been sexually abused.
6. 12% reported other types of abuse, including spiritual and verbal abuse, isolation, stalking, and animal abuse.
7. The responses by women in urban and rural communities on types of abuse were very similar.
8. Almost half of the women had suffered abuse in a previous relationship. Nearly half had been abused as children, and half had witnessed abuse as a child.
9. Almost two thirds had two or more separations; 40% had separated from their partner between two to four times; nearly one quarter had left their partner on five or more occasions. 35% had never separated or only separated once.

The surveys of women yielded the following demographic information:

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<sup>490</sup> "Exploring the Links," p. 5.

<sup>491</sup> "Exploring the Links," p. 5.

1. A significant majority were in common-law relationships rather than married. This is consistent with other research showing that women in common law marriages are at significantly greater risk of abuse than those in marriages.
2. 71% were unemployed—significantly more than women in the general population of both provinces. Most were receiving unemployment or social assistance benefits, but more than a quarter had no source of income. The authors noted that these women would likely feel trapped in their relationships because of their financial circumstances.
3. The majority had children.

The women surveyed provided the following information about firearms:

1. 28% of the rural women said there were firearms in their homes, the vast majority of which were long guns; 15% of the urban women had firearms in their homes.
2. Nearly 40% of women who said there were firearms in their homes said their partner did not have a license, and 44% said the firearms were not registered. Half said the firearms were not kept locked, and 11% said the guns were kept loaded. Many of the women did not know this information. There was less compliance with laws on registration, certificates, and storage in rural areas than in urban areas. The authors said their qualitative interviews suggested that both the rates of firearms in the homes and the rates of compliance was lower than the rates reported in the surveys.
3. Two thirds of the women with firearms in their homes said the presence of the firearms made them more fearful. 70% said it affected their decisions about whether to tell others about the violence they had experienced or seek help; where the women knew the firearms were kept loaded and/or unlocked, that number increased. In interviews, some women suggested their fears were heightened so as to make them more reluctant to report or seek help. Some women said they feared that their partner would become angry if his firearms were confiscated, which discouraged them from calling the police. Some women also feared that their partner would harm or kill a pet or farm animal if they left.
4. More than 60% of women with firearms in the home feared that their partner would commit suicide.

The authors stated:

In summary, the findings of our survey show that the presence of firearms in abusive homes can easily become instruments of intimidation and control. The majority of women indicated that it made them more fearful and had an [e]ffect on their decision to tell others about their circumstance. Women expressed greater concern for their own safety and that of their children as a result of firearms in the home. These fears were heightened when the firearms were not licensed or not stored properly, a reality in a large percentage of the cases. Women in rural communities, who are often geographically isolated, may feel especially vulnerable. Threats of suicide or alcohol or drug abuse are likely to increase during period of high stress or crisis such as illness and unemployment. However, when firearms are accepted as part of rural culture, it is possible that their potential for misuse in abusive situations is minimized. Hence women may be reluctant to express their fears about the firearms, or if they do, they may not be taken seriously. This constellation of economic and social factors in rural areas, in combination with the rapid decline in services and programs,

may set the stage for potentially lethal outcomes for abused rural women when firearms are present in the home.<sup>492</sup>

The women surveyed provided the following information about animals:

1. The majority of households had a pet or farm animal, and almost half said their partners had threatened to harm those animals.
2. Four in ten said their partner had harmed or killed their pet(s).
3. These numbers were higher in homes with firearms.
4. More than a quarter said that concern for the animals in their homes made them more reluctant to report or seek help.
5. A quarter of those with children said their children were aware that an animal had been harmed or threatened with abuse.

The authors concluded that “threats to pets and farm animals’ safety are a powerful way to intimidate, control, and abuse women. The situation is more pronounced when firearms are present. In homes with firearms, more women said that their partner had deliberately threatened to harm the animals or actually had harmed them than in homes without firearms. The women’s attachment to their pets and farm animals was often significant, but shelters would not take pets (and of course there were no facilities for farm animals), particularly in rural areas. Due to the common-law nature of many of the relationships, the men were also assumed to be the owners of the animals, so the women would not have had the option to take them if they left. The women expressed anguish at having to leave their animals; they feared, often rightly, for the animals’ safety, and their children were also devastated to leave them. In the focus groups and interviews, some women described their partners harming or tormenting their animals as a proxy for harming the women, noting that the women would be devastated by the abuse, but the police would not take any action. They expressed frustration at the lack of response by officials to instances of animal abuse. The authors recommended that officials take much more seriously threats to or mistreatment of animals when considering potential lethality and when considering obstacles to women seeking help. The authors also noted research showing that many children in homes where there was animal abuse were exposed to that abuse and also participated in it. They also cited research showing that childhood cruelty to animals has been identified as a risk factor for perpetrating violence against others in adulthood.

During the interviews and focus group discussions, women who identified as living in rural communities described the positive aspects of rural life:

Those we talked to who grew up in small towns and rural communities consistently referred to their communities as “close-knit” or having “strong inter-connections” or simply that “everybody knows everybody.” As several people told us, “When you drive through town, you are waving to everybody you see.” We were also told that independence and loyalty to families and friends are characteristic of people living in rural communities. This means that people do not interfere in their neighbour’s personal or family lives; however, they are always willing to lend a hand in other ways. This reinforces another much valued characteristic of rural life, which is the feeling of “safety”—people look out for one another. A police officer in the study confirmed that neighbourly concern is quick to arise:

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<sup>492</sup> “Exploring the Links,” p. 57.

If there was a strange car in the driveway, we would get a call to tell us who was behind the wheel, what they're doing, if they scratched their head, got out to kick the tire. We'd get that information. And it's all because, well, y'know, that car's never been in her yard before.<sup>493</sup>

However, others who had moved to rural communities found it difficult to become part of the social community. They were considered “from away” even after living in the community for many years.

Moreover, despite the benefits of close-knit community, participants said that living in rural communities also brings isolation. They also referred to the lack of services in these communities, including hospitals, mental health services, and police. One participant said, “When you talk about ‘rural communities,’ you know you live in a rural community when you see two RCMP cars going in one direction, you can do anything you want in the other direction.”<sup>494</sup> The authors referred to a lack of services as “a defining characteristic of rural communities.”<sup>495</sup> They also cited research that found that resources designed to prevent and treat incidents of family violence are disproportionately allocated to urban centres. Most research studies also take place in urban centres, leading to a lack of information on intimate partner violence in rural communities.

Gender stereotyping was still common in many rural communities. This was seen to encourage submissive and subservient roles for women that revolve around the household and family. Many women had also moved into their partners’ communities, where the men had strong family and community ties, and faced intense pressure to stay in their relationships. Reporting abuse in this context was considered a betrayal of the family. Victims of violence felt stigmatized and feared that in such tight-knit communities, everyone would know their business if they called the police. A number of women and service providers also commented on the frequent presence of police scanners in the homes of community members. Knowing that their neighbours or other members of the community might hear their calls to the police also discouraged them from doing so, particularly because their abuser could thereby learn of their call.

The authors also found that community members faced barriers to reporting suspected abuse:

Not only are abused women fearful about calling the police, we also heard that friends and neighbours can be fearful. There is a concern that even though one might try to make a confidential report, soon everyone would know. In the section of this report on experiences with the police, we discuss how the prevalence of police scanners in rural homes is a deterrent to reporting family violence. People were reluctant to call for help since “everyone” would know who called and what the police are doing. If a man has a violent temper, even if it is “only when he’s drinking,” the entire community may be fearful of retribution if they try to intervene or call for help. In some instances, people in the study actually felt that the police were fearful of certain families:

That’s actually happening in our community, with a family, where, they’re pretty sure there’s abuse, I mean, you know it, but people are afraid because it is isolation. The male in that situation is very violent, can be. I stopped [the neighbour] one day and talked to her, but she said they don’t dare to call because if anybody came out, he would know that it was them... and he would come after them with a gun. But it’s a real, real fear, and we don’t have police come out and patrol. There’s never any sign of any cops unless there’s an incident, and they’re called out. So there, it’s too late.<sup>496</sup>

The participants identified the strong attachment that people in rural communities have to firearms and the long traditions of hunting in both provinces. Participants themselves often had no fear of

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<sup>493</sup> “Exploring the Links,” p. 64.

<sup>494</sup> “Exploring the Links,” p. 65.

<sup>495</sup> “Exploring the Links,” p. 77.

<sup>496</sup> “Exploring the Links,” p. 76.

guns, having grown up with them in the house. They explained resistance to the gun registry as relating to rural people's dislike of government control over people's lives. The authors cited research showing that Canadian gun owners are typically older men who use the guns for hunting, target practice, and pest control, while Americans are more likely to identify protection and personal safety as their reasons for owning guns. They noted, however, that a number of participants told them that their partners kept guns in the house for protection, with one saying her husband had told her he had it "to shoot somebody if they came into the house." Others identified prestige and power as reasons their partners owned guns, with one saying her partner kept guns because "he's a nut. He likes power. He likes to be powerful. He thinks he's so big and cool and scary."<sup>497</sup> The authors said:

Most people hold positive sentiments about firearms; however, many people tend to hold a rather cavalier attitude towards the storage of firearms, and it is not uncommon to find firearms unlocked, in easy reach of children, with ammunition on hand. Firearms seem to be kept increasingly for personal safety, and some of the participants expressed concerns that this might contribute to accidental shootings. In homes where there are mental health problems or abuse, the threat of firearms misuse, even indirectly, was seen to contribute to a heightened sense of fear and risk of lethality.<sup>498</sup>

The authors noted, "There is a level of terror and intimidation created by the very presence of the firearm" when a woman has experienced coercion and/or physical abuse from their partners. The women surveyed described their partners raping them at gun point, looking at the gun on the wall during a dispute so as to suggest they would use the gun if the woman didn't comply, and numerous other examples of abuse facilitated by the presence of firearms. Many participants felt there was a widespread tendency to underestimate the risk of lethality faced by rural women experiencing abuse. The "gun culture" in rural communities led even professionals to underestimate the risk posed by the presence of guns.

The Report also noted that the fear of retaliation with a firearm can affect family, neighbours, and service providers, making them afraid to report when they witness abuse. In addition, participants were generally unaware of the toll-free number to report firearms abuse to the Canada Firearms Program. The authors concluded from the discussions with participants that the number of unregistered firearms is likely much higher in rural communities than is reported, and many owners of firearms may have several hidden in their homes. Many women also said that when police responding to intimate partner violence calls asked them if their partners had guns, they would say no. They did not trust that anything would be done about it and feared that they might be at greater risk if they reported the weapons. Confiscated guns are often returned, even where the owner is charged with unsafe storage or other acts. They also said that even if their partner's gun was confiscated, their partner might have others hidden in their home or on their property or would easily be able to find another firearm from a neighbour. They suggested that where weapons have been confiscated from an abuser, the police should search every few months to ensure the abuser had not obtained another firearm.

The Report also noted that many women never call police about abuse, and if they do, they do so only in order to respond to an immediate crisis. They are reluctant to further engage in the criminal justice process through assault charges, over which they have no control and which rarely

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<sup>497</sup> "Exploring the Links," p. 71.

<sup>498</sup> "Exploring the Links," p. 73.

lead to convictions and can make them vulnerable to repercussions. For similar reasons, they are also reluctant to further engage in the criminal justice system through firearms-related charges.

The abusers also often threatened to kill themselves, making it harder for women to leave:

We heard repeatedly of women who were reluctant to leave an abusive relationship because of their partners' threats to commit suicide—"If you leave, I'll kill myself." Suicide threats place women in a dilemma. This man that they want to leave might be the father of their children, well-liked in the community, and someone they still have feelings for. If a woman leaves an abusive relationship and her partner kills himself, there is a strong, often realistic, belief that people will blame her.<sup>499</sup>

The Report also noted the limitations of the firearms registration process, which places an onus on spouses to report any concerns about the applicant's possession of a firearm. They suggested that spouses and former partners instead be contacted during an investigation triggered through other means. They also suggested mandatory confiscation of firearms upon report by a health provider that a person with access to firearms is suicidal. The authors concluded:

Although we must exercise caution in extrapolating lethality risk based solely on the association of firearms misuse in the intimidation and control of women in domestic situations, the strong correlation between the highest firearms ownership rates and the highest rates of firearms deaths from homicide, suicide and accident is well documented ...

The prevalence of firearms in rural homes generally, along with the cavalier attitude towards safe storage and their association with control and intimidation in homes experiencing family violence, is undeniable. Yet the "gun culture" in rural communities has never really been recognized as a factor that must be considered in assessing risk given its role in creating a lack of attention to women's safety and an under-estimation of potential risk.<sup>500</sup>

A number of police officers were interviewed for the study. Their responses to questions about calls about intimate partner violence made it clear that there is no uniform practice with respect to responding to calls involving weapons. Some women reported feeling blamed by police when they did report abuse. Others reported positive experiences with police, but felt they were lucky. The Report's recommendations, some of which were made by study participants and some of which were made by the authors, included creating pro-removal and pro-confiscation firearms policies, similar to pro-arrest and pro-charge policies. The study also recommended amendments to the Criminal Code to permit police to search for firearms without a warrant in all domestic disputes, even where a firearm was not involved in the dispute.

The Report also recommended training police and others who work with abused rural women on firearms victimization in rural homes in order to counter the normalization of firearms in these communities. The Report recommended public education on abuse of animals and the impact of threats to animals on women who are considering leaving relationships, legislation to protect victims' animals, and linking animal abuse to child abuse and senior abuse.

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<sup>499</sup> "Exploring the Links," p. 98.

<sup>500</sup> "Exploring the Links," pp. 101–2.

### Recommendations Relevant to the Mandate of the Mass Casualty Commission<sup>501</sup>

1. Ensure that risk assessment tools include questions about the misuse and abuse of firearms, as well as pet abuse. Transition houses and victims services should include questions about firearms and firearms abuse on their intake forms and routine questionnaires. Questions about the presence of firearms should include questions on indirect victimization and ongoing firearms abuse.
2. Support a series of gun safety commercials targeted at rural communities/provinces.
3. Publicize the family violence provisions of the Firearms Act. There be more education on the purpose of the toll-free line, who should call, what would happen, and so on. When the Chief Firearms Officer conducts an investigation of an applicant or licensee for any reason, they should use such opportunities to ask the partner a series of questions about direct and indirect firearm's victimization, destruction of property, concerns about suicide, and threats to harm pets/farm animals.
4. Create pro-removal and pro-confiscation firearms policies similar to pro-arrest and pro-charge policies.<sup>502</sup> Guns should be automatically removed from the home at the first domestic violence call. The Criminal Code should be amended to allow the police to search for firearms without a warrant in all domestic disputes, even those where the incident itself did not involve a firearm. When considering whether to apply for preventive prohibition orders on the grounds that the firearm poses a risk to public safety, the onus should be on the police to demonstrate that the woman is not fearful. Police must also be better informed of what constitutes "risk" and must ask questions that reveal not only direct violations such as pointing the firearm but also indirect threats to either kill her, family members, or a pet, and certainly threats to commit suicide. Removal practices should therefore become more standardized in relation to police discretion to apply for a preventive protection order. If firearms are returned, they should go back with safety locks and a requirement for the owner to participate in a gun safety course. To better support police in their efforts to remove firearms, the National Weapons Enforcement Support Team (NWEST) should be expanded and additional RCMP experts be seconded to New Brunswick and Prince Edward Island to give direct support to police officers. (There were only two in each province.)
5. Confiscate firearms for unsafe storage violations.

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<sup>501</sup> These recommendations, which were unnumbered in the Report, have been condensed and at some points paraphrased from the original text.

<sup>502</sup> The authors noted that although they attempted to make recommendations which reflected a consensus among study participants, the study participants did not unanimously support the recommendations regarding firearms confiscation. They said, "While we have attempted to reflect areas of consensus with respect to solutions, it should be noted that sometimes the opinions on what should be done to address a particular aspect of firearms victimization varied. For example, some people felt that police and crisis workers must adopt a 'zero tolerance of firearms' policy that would result in the immediate search and seizure of firearms in any domestic case – even a routine "domestic argument". Finding and removing all firearms in any domestic violence case was seen as the only remedy to end firearms victimization. Others felt that routine and automatic confiscation of firearms for every domestic call was impractical and would only contribute to the "code of secrecy" and drive the problem further "underground". Instead, they argued, we should educate women about lethality risks and encourage them to disclose their fears of being harmed with firearms so that authorities can then take appropriate steps to remove the firearms. Those calling for confiscation argued that relying on women to disclose would bring us back full circle to the finding of this research - that women are afraid to disclose or that they normalize their fear in relation to firearms victimization. In the final analysis, although we have tried to carefully and respectfully weigh all of the suggestions, the co-principal investigators must take sole responsibility for the following recommendations. They are intended to stimulate discussion, exploration and debate." "Exploring the Links", p.154

6. Educate police, justice officials, and service providers on the nature and extent of firearms victimization in rural homes. It is recommended that police, social workers, crisis workers, and others who work with abused rural women receive training to help them to understand and identify the nature of firearms victimization in abusive homes. The training would make the link to other factors that exacerbate risk when firearms are present, such as alcohol/drug addiction, harming pets/farm animals, mental health problems, including threatening suicide, and so on.
7. Encourage abused women who are considering leaving an abusive relationship where firearms are present to think about personal safety issues for themselves and their children. It should be explained to women that separation can be an extremely dangerous time and that they must have a safety plan not only for living with and leaving abuse but for living separately.
8. Restrict firearms access on stay-away and no-contact orders, and peace bonds in all domestic cases.
9. Ensure follow-up and support for victims following charges and better enforcement of protective orders. Breaches must be taken seriously and result in immediate incarceration.
10. Enact legislation to compel certain professionals (mental health workers and doctors) to report concerns about the stability of gun owners.
11. Create a Public Education Campaign regarding the abuse of pets and farm animals to control and intimate spouses, encouraging people to show respect and sensitivity to victims of abuse who were concerned about their animals. This would include education about the risks associated with family violence and the presence of firearms, abuse of animals, and other factors uncovered in the research study.
12. Ensure that questions about pet/farm animal abuse are included on intake forms and risk assessments.
13. Develop a safe haven program for pets and farm animals. Communities should set up safe shelters for animals of abused women, where woman and children could maintain contact with the animals until they could recover their animals.
14. Provide stronger legal protections for the animals of victims of domestic violence, including education and training on those protections. The connection between family violence and animal abuse should be recognized in our laws.<sup>503</sup>
15. Award “custody” of pets to the victim, including when awarding exclusive possession orders.
16. Link animal abuse to other forms of abuse, including child abuse and senior abuse. In order to ensure coordination, governments should amend child protection legislation to require animal welfare officers and others who suspect animal abuse to report their concerns to child welfare authorities as a possible form of child abuse and/or family violence.<sup>504</sup>
17. Develop public education initiatives on the different faces of family violence. Service providers, government, and others should work together to develop a three-pronged general public education strategy—for abused women (with an emphasis on rural women), for their communities, and for the professionals with whom they come into contact. Schools and other venues to reach youth should be included in this education campaign. This education should address questions such as:

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<sup>503</sup> At the time of the study, Prince Edward Island permitted the inclusion of pets in Emergency Protection Orders, but there was little enforcement of it, in part due to a lack of public awareness of this option.

<sup>504</sup> The authors noted that Prince Edward Island already required this.

- a. how abusive behaviours manifest themselves, create fear, and contribute to risk;
  - b. how people minimize those behaviours;
  - c. indicators of risk for women experiencing abuse;
  - d. the nature and forms of firearms victimization in violent relationships;
  - e. safety planning addressing firearms risk and victimization;
  - f. the links between risk/lethality and firearms, alcohol, animal abuse, threats of suicide, and other mental health issues; education about pet abuse and firearms victimization is particularly crucial in rural communities.
18. Create a network of safe places in rural communities where women feel safe to disclose abuse. These could assist the many rural women who do not wish to leave their communities to go to a transition house; they could be located in workplaces, social service offices, faith communities, or hospitals. In addition, stand-alone “women’s centres” could provide these women with additional assistance with housing, employment, legal aid, and programs to increase self-esteem.
  19. Coordinate services and improve communication among all service providers. This is particularly important for abused rural women who face significant barriers to travel to multiple service providers. A toll-free crisis hot line and/or rural outreach centres could also assist.
  20. Raise the confidence and self-esteem of abused rural women. Service providers must encourage survivors of abuse not to blame themselves and validate their suffering.
  21. Coordinate risk assessment tools to ensure that they incorporate research-supported, evidence-based risks such as abuse of pets, indirect fears of firearms, the prevalence of abuse among common-law couples, etc. The findings of this study should be incorporated into all risk assessment tools, particularly those used in rural provinces.

## 6.9. Nunavut, Northwest Territories, Northern Quebec, and Northern Newfoundland and Labrador

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### 6.9.1. Addressing Gendered Violence against Inuit Women: A Review of Police Policies and Practices in Inuit Nunangat (Pauktuutit Inuit Women of Canada and Public Safety Canada, 2020)<sup>505</sup>

This review of responses to gender-based violence in Inuit Nunangat (the homeland of Inuit people, consisting of the Inuvialuit region of the Northwest Territories, Nunavut, Nunavik in northern Quebec, and Nunatsiavut in Newfoundland and Labrador) by Dr. Elizabeth Comack, Department of Sociology and Criminology at the University of Manitoba, was funded by Public Safety Canada as part of its response to the MMIWG Inquiry (summarized above in section 6.2.7.). The Public Safety website notes that the contents reflect the views of the author and participants.<sup>506</sup> The RCMP is responsible for policing in Inuit Nunangat, except for Nunavik, which is policed by the Kativik Regional Police Force (KRPF).

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<sup>505</sup> “Addressing Gendered Violence against Inuit Women: A Review of Police Policies and Practices in Inuit Nunangat,” Pauktuutit Inuit Women of Canada and Public Safety Canada (January 2020), <https://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/rvw-plc-prctcs-pauk/index-en.aspx>.

<sup>506</sup> See “Disclaimer,” <https://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/rvw-plc-prctcs-pauk/index-en.aspx>.

Dr. Comack interviewed 45 Inuit women and 40 police officers in the four regions. She made the following findings:

1. Inuvialuit participants believe that gendered violence has become “normalized” for Inuit women as a result of the residential school system and colonialization. They commented on the continual rotation of officers, the failure of police to respond to calls for help to deal with situations of intimate partner violence, victims being removed from the home instead of the abusers, failure to monitor and respond to court-imposed sanctions, and women not being taken seriously when they expressed fears for their safety. One officer referred to being frustrated with “women who utilize the criminal justice system to play a vindictive game against their partners.”<sup>507</sup>
2. Nunavut participants also expressed concern about the pervasiveness of intimate partner violence in their community. They reported slow police response times, poor treatment when they reported gendered violence, language barriers, high turnover of officers, officers’ inexperience in the north, lack of community resources, a lack of visible RCMP presence in their community, racialized assumptions in officers’ response, and a legacy of tension from the colonial history of police–Inuit relations. They also expressed the need for efforts to support police dealing with vicarious trauma.
3. In Nunatsiavut, participants reported reluctance to report violence because of isolation, reliance on their partner, threats from their partner, the length of time it takes to process criminal charges, and a lack of trust in police and the criminal justice system. Several women reported that police were unsupportive or jeopardized their safety, and in some cases the response was unprofessional and racialized. They also cited slow response times. They noted that officers do not interact in the community and suggested that the RCMP needs to work at building trust and rapport with community members. They also suggested that training in how to respond to disclosures of sexual violence and hiring more female police officers would help. More resources and social services and better coordination of services would also assist.
4. In Nunavik, women reported a lack of trust in police and reported improper responses to reports of gendered violence. One woman reported violence from a police officer; others reported that they were removed from their homes instead of the perpetrator. No-contact orders do not work in small communities. For many participants, the police are an outside force, and their form of justice runs counter to the Inuit way of resolving conflicts. KRPF officers are poorly integrated into the community and do not understand the history of the community or the reasons for the problems in the community; language barriers exacerbate the problem. Police are also under-staffed.

Dr. Cormack concluded that the problems with policing in Inuit Nunangat relating to domestic violence require a fundamental shift, making the police part of community revitalization and involving the police in a process of decolonization. Police need to assimilate into Inuit ways, rather than the reverse.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission<sup>508</sup>**

1. Investments must be made to provide police with adequate training in trauma-informed approaches to policing. This training must be made relevant to the history and contemporary experiences of Inuit. With a firmer understanding of trauma and its indicators, police will be

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<sup>507</sup> “Addressing Gendered Violence against Inuit Women,” p. 7.

<sup>508</sup> Recommendations were not numbered in the Report.

better positioned to de-escalate situations, build more positive relationships with the community, and assist in ensuring community wellness and safety.

2. To help manage the personal stress resulting from daily policing activities in Inuit communities and the effects of vicarious trauma on first responders, police officers should be encouraged to seek emotional support and guidance from community elders, counsellors, or natural helpers.
3. Police officers must undergo ongoing specialized education on the dynamics of gender-based violence, training that would be more effective if it were delivered, at least in part, by victims' advocates. Second only to victims, advocates have the most comprehensive understanding of the realities of gender-based violence. An enriching element to the training would be the inclusion of input from Inuit survivors of domestic violence to educate the police on their experiences.
4. Police protocols, including investigative strategies to respond to sexual assault and domestic violence, must be evaluated and revised to ensure that the police are responding in a culturally appropriate and victim-centred manner.
5. To achieve a more supportive experience for female survivors of gendered violence, there should be a female police officer present, if not leading, the statement-gathering process.
6. Gendered Violence Prevention Liaison: This community-based position would be geared toward providing those harmed by gendered violence with a dedicated support person tasked with coordinating access to resources offered by police and other social service agencies. Such a position would enhance partnerships between agencies in ensuring the multiple needs of those harmed by gendered violence—safety planning, counselling, housing, etc.—are being met.
7. The RCMP and KRPf should develop protocols for introducing new officers to the communities they serve. These protocols would be developed in close consultation and collaboration with Inuit community leaders, elders, and cultural facilitators. The aim would be to reinforce officers' accountability to those communities as well as to facilitate the integration of officers into the community.
8. The RCMP should reconsider the policy of limiting postings to two years in duration. Where possible, posting contracts should be extended to sustain positive rapport between Inuit community members and regular service members and enable trust and reciprocity to be built into police–community relations.
9. Investments must be made to create Inuit Nunangat-specific, bilingual public education programs in two main areas:
  - a. Education about the criminal justice system: To provide information to the public on the role and function of the police and citizen's rights in relation to the criminal justice system, these programs could take the form of messages through routine uses of existing media, such as television, radio, newspapers, and social media, as well as a variety of local community forums.
  - b. Education about gender-based violence: To foster confidence in the criminal justice system, police need to take a key role in the development, design, and implementation of gender-based violence prevention and education efforts. This task could be accomplished through the police leading specialized workshops, campaigns, and programs focusing on encouraging victims to report abuse. Such police engagement with both the general community and those deemed to be at risk of gendered violence could help provide those suffering in silence with the assurance that the police are

available to assist them, thereby increasing women’s confidence in police and reducing their reluctance to report abuse.

10. Police integration and presence in the community should be enhanced through planned events (such as sewing circles) and the dissemination of positive police–citizen encounters (through social media) in order to build trust and a positive police–community relationship.
11. Given that policing is an essential service, the Government of Canada must ensure that all regions of Inuit Nunangat have effective and substantively equitable policing services. In addition, the government has a responsibility to ensure equitable funding of victim services in every community across Inuit Nunangat.

## 6.10. Prince Edward Island

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### 6.10.1. Inquest into the Deaths of Patricia Lynn Hennessey and Nash David Campbell (Prince Edward Island, 2015)<sup>509</sup>

This inquest reviewed the deaths of four-year-old Nash Campbell and his mother, Patricia Hennessey. According to media reports,<sup>510</sup> their bodies were found in a burned-out Jeep in western Prince Edward Island. They had both been sedated and died of smoke inhalation. The medical examiner determined that Ms. Hennessey had killed Nash and herself.

The RCMP had been involved in dozens of incidents between Ms. Hennessey and Nash’s father, Marc Campbell. Two years before the murder-suicide, Ms. Hennessey was arrested for impaired driving and mischief after smashing her car into Mr. Campbell’s car. She told police she would kill herself and Nash because of what police had done to her and said “Your dues will come.” Two months later, she attempted suicide twice, leaving notes saying she that couldn’t take the custody battle anymore. On another occasion, Mr. Campbell told police that Ms. Hennessey had threatened to “make him pay.” All charges against Ms. Hennessey and Mr. Campbell arising from reports to police were stayed or withdrawn, except the impaired driving and mischief charges, for which Ms. Hennessey was sentenced to two weeks in jail. Child protection authorities were involved after Mr. Campbell’s mother contacted them to report concerns about Ms. Hennessey. The RCMP believed the complaints to police were escalating because of the custody dispute. However, they believed their hands were tied, as the child did not appear to be at imminent risk. A meeting with the parents, the child protection worker, and police, intended to try to resolve the dispute, did not go ahead because the worker was not available.

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<sup>509</sup> “Hennessey-Campbell Inquest: Chief Coroner’s Comments and Jury’s Recommendations” submitted to the PEI Minister of Justice and Public Safety (June 2015),

[https://www.princeedwardisland.ca/sites/default/files/publications/chief\\_coroners\\_recommendation\\_to\\_minister.pdf](https://www.princeedwardisland.ca/sites/default/files/publications/chief_coroners_recommendation_to_minister.pdf)

<sup>510</sup> See “Pathologist Testifies at Patricia Hennessey, Nash Campbell Inquest” *CBC News* (9 March 2015), <https://www.cbc.ca/news/canada/prince-edward-island/pathologist-testifies-at-patricia-hennessey-nash-campbell-inquest-1.2986753>; “Final Hours before Murder-suicide Captured in Text Messages” *CBC News* (11 March 2015), <https://www.cbc.ca/news/canada/prince-edward-island/final-hours-before-murder-suicide-captured-in-text-messages-1.2990982>; “Patricia Hennessey Threatened Murder-suicide, Inquest Hears” *CBC News* (9 March 2015), <https://www.cbc.ca/news/canada/prince-edward-island/patricia-hennessey-threatened-murder-suicide-inquest-hears-1.2988045>; T. Wright, “Chilling Details from Murder/Suicide Involving Toddler” *SaltWire* (10 March 2015), <https://www.saltwire.com/atlantic-canada/federal-election/chilling-details-from-murdersuicide-involving-toddler-78878/>.

The day before the bodies were found, a judge had granted custody of Nash to Mr. Campbell, with access visits to Ms. Hennessey. The parties and judge agreed that Ms. Hennessey would bring Nash to daycare the next morning, and Mr. Campbell would pick him up. The evening the order was made, Ms. Hennessey took Nash out. Her sister repeatedly asked Ms. Hennessey over text to bring Nash home. Ms. Hennessey refused. Ms. Hennessey texted to a friend that “Nash is not going to that monster” and “This is the end of my life.” She texted Mr. Campbell that she had vowed to protect Nash from him and his parents. The Jeep was found two hours later, in flames.

A coroner’s inquest was held over four days in March, 2015, and made fifteen recommendations. The Coroner commented on each of the recommendations in a letter to the Minister of Justice and Public Safety. He also noted the lack of counselling or support provided to members of the jury, who found it very difficult to manage the graphic evidence presented to them.

### **Recommendations Relevant to the Mandate of the Mass Casualty Commission**

- (Recommendation 1) Health care workers should be provided additional education in recognizing risks for filicide and strategies for prevention.
- (Recommendation 2) Child protection policy and protocol [procedure] regarding the identification and management of high-risk cases need to be updated.
- (Recommendation 3) There needs [to be] more training for Child Protective Services [CPS] workers on parental engagement.
- (Recommendation 4) There needs to be mandatory multidisciplinary training on domestic violence and child abuse.
- (Recommendation 5) There should be better information-sharing between families and the justice system.
- (Recommendation 6) There needs to be judicial education on domestic violence and child abuse.
- (Recommendation 9) There needs to be a strategy in place to assure [sic] that employees who are dealing with domestic violence or mental health issues receive workplace support.
- (Recommendation 11) There needs to be more aggressive enforcement of custody arrangements, with justice system consequences such as criminal charges available if the terms of child custody are violated.
- (Recommendation 13) Every high-risk family should have a “Safety Circle.”
- (Recommendation 15) Government should consider creating a provincial position for “Child Advocate

## 7. APPENDIX: REPORTS IDENTIFIED IN THE ENVIRONMENTAL SCAN

Section	Report	Year	COMM ID
2.1.1	<a href="#">Royal Commission on the Donald Marshall Jr. Prosecution (Nova Scotia)</a>	1989	COMM0058285
2.1.2.	<a href="#">Inquiry into Matters Relating to the Death of James Baily, Jr. (Nova Scotia Police Commission)</a>	2005	COMM0058286
2.1.3.	<a href="#">Inquiry into Matters Relating to the Death of Dean Richard (Nova Scotia Police Commission)</a>	2005	COMM0058287
2.1.4.	<a href="#">Victoria Rose Paul Investigation (Nova Scotia Police Complaints Commission)</a>	2012	COMM0058288
2.1.5.	<a href="#">Inquiry into the Death of Howard Hyde (Nova Scotia Provincial Court)</a>	2010	COMM0058289
2.2.1.	<a href="#">Aboriginal Justice Inquiry of Manitoba (Manitoba)</a>	1991	COMM0058290 to COMM0058292
2.2.2.	<a href="#">Rebuilding the Trust: Federal Task Force on Governance and Cultural Change in the RCMP (Canada)</a>	2007	COMM0058293
2.2.3.	<a href="#">Kingsclear Public Interest Investigation Report (Commission for Public Complaints Against the RCMP)</a>	2007	COMM0058955
2.2.4.	<a href="#">Police Investigating Police (Commission for Public Complaints Against the RCMP)</a>	2009	COMM0059001
2.2.5.	<a href="#">Braidwood Commission on the Death of Robert Dziekanski (British Columbia)</a>	2010	COMM0058954
2.2.6.	<a href="#">Sharing Common Ground: Review of Yukon's Police Force (Government of Yukon)</a>	2011	COMM0058294
2.2.7.	<a href="#">Independent Civilian Review into Matters Relating to the G20 Summit (Toronto Police Services Board) (Ontario)</a>	2012	COMM0058295
2.2.8.	<a href="#">Police Encounters with People in Crisis (Independent Review) (Toronto Police Service) (Ontario)</a>	2014	COMM0058296
2.2.9.	<a href="#">Chairperson-Initiated Complaint and Public Interest Investigation regarding Policing in Northern British Columbia (Civilian Review and Complaints Commission for the RCMP)</a>	2017	COMM0058297
2.2.10.	<a href="#">Independent Police Oversight Review (Ontario)</a>	2017	COMM0058298
2.2.11.	<a href="#">Halifax, Nova Scotia: Street Checks Report (Nova Scotia Human Rights Commission)</a>	2019	COMM0058299
2.2.12.	<a href="#">Independent Review of the Manitoba Police Services Act</a>	2020	COMM0058300
2.2.13.	<a href="#">Broken Dreams, Broken Lives: Implementation of the Merlo Davidson Settlement Agreement (RCMP)</a>	2020	COMM0058301
2.2.14.	<a href="#">Chairperson-Initiated Complaint and Public Interest Investigation into the RCMP Investigation of the Death of Colten Boushie (Civilian Review and Complaints Commission for the RCMP)</a>	2021	COMM0063058

7. APPENDIX: REPORTS IDENTIFIED IN THE ENVIRONMENTAL SCAN

2.2.15.	<a href="#">Systemic Racism in Policing in Canada (Standing Committee on Public Safety and National Security)</a>	2021	COMM0058303
2.2.16.	<a href="#">Missing and Missed: Independent Civilian Review into Missing Person Investigations in Ontario (Toronto Police Services Board) (Ontario)</a>	2021	COMM0058304 to COMM0058307
2.2.17.	<a href="#">Transforming Policing and Community Safety in British Columbia: the "Routley Report" (Special Committee on Reforming the Police Act) (British Columbia)</a>	2022	COMM0058952
3.1.	Kaufman Commission on Proceedings Involving Guy Paul Morin (Ontario)	1998	COMM0058308
3.2.	<a href="#">Inquest into the death of Jonathan Yeo: Verdict of the Jury (Office of the Chief Coroner of Ontario)</a>	1992	COMM0058309
3.3.	<a href="#">Bernardo Investigation Review ("Campbell Report") (Ontario)</a>	1996	COMM0058310 to COMM0058311
3.4.	<a href="#">Commission of Inquiry into the Actions of Canadian Officials in Relation to Maher Arar</a>	2006	COMM0058312
3.5.	<a href="#">Forsaken: The Report of the Missing Women Commission of Inquiry (British Columbia)</a>	2012	COMM0058313
4.1.	<a href="#">Review of the Investigation of Sexual Assaults, Toronto Police Services (Toronto Audit Services)</a>	1999	COMM0058314
4.2.	<a href="#">The Ipperwash Inquiry (Ontario)</a>	2007	COMM0058315 to COMM0058318
5.1.	<a href="#">Public Fatality Inquiry into the Deaths of James Wilbert Galloway and Martin Charles Ostopovich ("Galloway Inquiry") (Alberta)</a>	2006	COMM0058953
5.2.	<a href="#">Public Fatality Inquiry into the Deaths of Constables Anthony Gordon, Lionide Johnston, Brock Myrol, Peter Schiemann, and Mr. James Roszko by Assistant Chief Judge Daniel Pahl (Mayerthorpe Inquiry)</a>	2011	COMM0058319
5.3.	<a href="#">Independent Review of the Moncton Shooting (New Brunswick)</a>	2014	COMM0058320
5.4.	<a href="#">R v The Royal Canadian Mounted Police (New Brunswick Provincial Court)</a>	2017	COMM0058321
5.5.	<a href="#">RCMP Security Posture: Parliament Hill October 22, 2014 (Ontario Provincial Police)</a>	2015	COMM0061100
5.6.	<a href="#">External Engagement and Coordination: Parliament Hill Incident After-Action Review (RCMP National Division Review Team)</a>	2015	COMM0061099
6.1.1.	Changing Perspectives: A Case Study of Intimate Partner Homicide in Nova Scotia (Health Canada)	1995	COMM0001238
6.1.2.	Nova Scotia Family Violence Tracking Project (1995)	1995	COMM0058325
6.1.3.	<a href="#">"From Rhetoric to Reality: Ending Domestic Violence in Nova Scotia" (Law Reform Commission of Nova Scotia)</a>	1995	COMM0047938

7. APPENDIX: REPORTS IDENTIFIED IN THE ENVIRONMENTAL SCAN

6.1.4.	Truro Police Service Program Review (Police and Public Safety Services Division of the NS Department of Justice)	2000	COMM0058327
6.1.4.	Department of Community Services Review, Maxwell/George Case	2000	COMM0058328
6.1.4.	Program Review into the Deaths of Lori Lee Maxwell and Bruce Allen George (Department of Justice)	2000	COMM0058329
6.1.5.	<a href="#">Review of the Framework for Action Against Family Violence (“Russell Review”) (Nova Scotia)</a>	2001	COMM0000370
6.1.6.	Evaluation of the Nova Scotia Domestic Violence Intervention Act (Department of Justice)	2006	COMM0000375
6.1.7.	<a href="#">Report of the Domestic Violence Prevention Committee (Nova Scotia)</a>	2009	COMM0000243
6.1.8.	<a href="#">The 2014 HRM Roundtable Review (“Clairmont Review”) (Halifax Regional Municipality)</a>	2014	COMM0058333
6.1.9.	<a href="#">Independent Review of the Police and Prosecution Response to the Rehtaeh Parsons Case</a>	2015	COMM0058334
6.1.10.	Independent Officer Review: Susan Olive Butlin – Ernie “Junior” Duggan Complaints (“H” Division, RCMP)	2019	COMM0048906 <sup>511</sup>
6.2.1.	The War Against Women: Sub-Committee on the Status of Women (House of Commons)	1991	COMM0058336
6.2.2.	<a href="#">Ad Hoc FPT Working Group Reviewing Spousal Abuse Policies and Legislation</a>	2003	COMM0058337
6.2.3.	<a href="#">Aboriginal Women and Family Violence (Indian and Northern Affairs Canada)</a>	2008	COMM0058338
6.2.4.	<a href="#">Ending Violence Against Aboriginal Women and Girls: Standing Committee on the Status of Women (House of Commons Committee)</a>	2011	COMM0058339
6.2.5.	<a href="#">Invisible Women: Special Committee on Violence Against Indigenous Women (House of Commons)</a>	2014	COMM0058340
6.2.6.	<a href="#">Promising Practices to Prevent Violence Against Women and Girls: Standing Committee on the Status of Women (House of Commons)</a>	2015	COMM0058341
6.2.7.	<a href="#">Reclaiming Power and Place: National Inquiry into Missing and Murdered Indigenous Women and Girls</a>	2019	COMM0058342 to COMM0058349
6.2.8.	<a href="#">The Shadow Pandemic: Stopping Coercive and Controlling Behaviour in Intimate Relationships (Standing Committee on Justice and Human Rights, House of Commons)</a>	2021	COMM0058350

<sup>511</sup> The Mass Casualty Commission has very recently received a less redacted version of the “Independent Officer Review” into Ms Butlin’s complaints. This appendix will be updated with the new COMM number for this report when it becomes available. The version listed here can be found at exhibit P-003649.

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6.3.1.	<a href="#">Public Fatality Inquiry into the Deaths of Blagica, Alex, and Josif Fekete (Alberta)</a>	2005	COMM0058351
6.4.1.	Coroner's Inquests into the Deaths of the Gakhal Family (the "Vernon Inquest") (British Columbia)	1996	COMM0058353
6.4.2.	Recommendations for Amendments to "E" Division RCMP Operational Policies Pertaining to Relationship Violence and the Processing of Firearms Applications (RCMP)	1998	COMM0050844
6.4.3.	<a href="#">Honouring Christian Lee – No Private Matter: Protecting Children Living with Domestic Violence (British Columbia Representative for Children and Youth)</a>	2009	COMM0058354
6.4.4.	<a href="#">Honouring Kaitlyne, Max and Cordon – Make Their Voices Heard Now (British Columbia Representative for Children and Youth)</a>	2012	COMM0058355
6.5.1.	Inquest into the Death of Margret Kasonde and Wilson Kasonde (Ontario)	1997	COMM0058356
6.5.2.	<a href="#">Inquest into the Deaths of Arlene May and Randy Iles (Ontario)</a>	1999	COMM0058357
6.5.3.	Inquest into the Deaths of Gillian Hadley and Ralph Hadley (Ontario)	2002	COMM0058358
6.5.4.	<a href="#">Inquest into the Deaths of Lori Dupont and Marc Daniel (Ontario)</a>	2007	COMM0058359
6.5.5.	Inquest into the Death of Vu Duy Pham and Frederick Preston (Ontario)	2012	COMM0058360
6.5.6.	Inquest into the Deaths of Carol Culleton, Anastasia Kuzyk and Natalie Warmerdam (Ontario)	2022	COMM0059741
6.6.1.	<a href="#">Fatality Inquest Respecting the Deaths of Doreen Leclair and Corrine McKeown (Provincial Court of Manitoba)</a>	2002	COMM0058361
6.7.1.	<a href="#">Public Fatality Inquiry: Brenda Mary Moreside (Minister of Justice and Solicitor General of Alberta)</a>	2013	COMM0058362
6.8.1.	<a href="#">Exploring the Links: Firearms, Family Violence and Animal Abuse in Rural Communities (New Brunswick and Prince Edward Island)</a>	2008	COMM0058363
6.9.1.	<a href="#">Addressing Gendered Violence against Inuit Women: A Review of Police Policies and Practices in Inuit Nunangat (Pauktuutit Inuit Women of Canada and Public Safety Canada)</a>	2020	COMM0058364
6.10.1.	<a href="#">Inquest into the Deaths of Patricia Lynn Hennessey and Nash David Campbell (Prince Edward Island)</a>	2015	COMM0058365