Frank Joseph PAUL
REASONS FOR DECISION

Background:

On December 6th, 1998, the body of Frank Joseph Paul was discovered in an alley in the downtown eastside of Vancouver. A postmortem examination of Mr. Paul's body determined that the cause of death was hypothermia due to or as a consequence of acute alcohol intoxication. Accelerated heat loss of the body was attributed to his rain-soaked clothing.

The discovery of Mr. Paul's body in the early morning hours of December 6th launched a chain of events with far reaching consequences. The troubling circumstances of Mr. Paul's tragic death are still, now some five years later, in need of a full public examination to determine what factors led to his death and how a similar tragedy may be avoided in the future.

Brief facts:

Very briefly stated, Mr. Paul was in police custody on two occasions on 5 December 1998. At 10:45 hours, police attended at 404 Abbott Street as a result of a telephoned complaint and found Frank Paul in a state of intoxication in a public place. He appeared to be intoxicated, uncooperative and unsuitable to take to a detoxification centre. Police therefore arrested Mr. Paul and transported him to the police jail at 312 Main Street. On arrival at the police jail, police reported that he was unable to keep his balance so he was guided to a wall where he slid down to a seated position. Police jail video shows Mr. Paul crawling on hands and knees to the elevator door at 11:22 hours. Correctional officers assisted him with the removal of wet clothing since he was unable to accomplish that by himself. Mr. Paul spent time in the "drunk tank" while his clothing was being dried and he was sobering up. By 16:57 hours the police jail surveillance video recorded Mr. Paul emerging from the jail elevator walking upright and unassisted by anyone. At 18:06 Mr. Paul walked out of the police jail. In the interim time, he can be seen on the video putting on a sweater and an outer jacket, unassisted; being handed a cup of coffee while he sat against the wall in the wagon bay area, and speaking to police officers prior to his departure.

Approximately two hours later, at 20:18, two Vancouver police officers once again arrested Mr. Paul for being intoxicated in a public place, having found him rain-soaked, lying on his back on a vegetable stand in the 400 Block of Dunlevy Street with the temperature at about 2 degrees C. The arresting officers reported that his speech was slurred and incoherent, he was unable to sit up or walk, and was apparently unable to care for himself. The police wagon driver then attended and transported Mr. Paul to the police jail. The arresting officer had

reported that Frank Paul could not stand and had to be carried and placed inside the wagon. At 20:25 hours, Mr. Paul arrived at the police jail and the jail surveillance video recorded the dragging of a motionless Frank Paul from the police wagon into the jail elevator; a visible wet trail left behind as his rain-soaked body was dragged along the concrete floor. Over the ensuing minutes a number of individuals are noted on the video to witness Mr. Paul's physical condition. He was seen by the Sergeant on duty who determined that he did not believe that Mr. Paul was intoxicated. The Sergeant had considerable experience with Mr. Paul who was an unemployed chronic alcoholic with no fixed address who had been "a regular" for some months at the city jail for being in a state of intoxication. The Sergeant reported that Mr. Paul's condition "did not appear any different to his usual state of post-gaol stay sobriety" despite the Sergeant's observing his actual state of sobriety when Mr. Paul walked out of the jail two hours earlier.

The Sergeant was unable to confirm any residence for Mr. Paul, who had been booked in as "no fixed address" and told the wagon driver to "breach Mr. Paul out of the [downtown] area". At 20:30 hours the jail surveillance video depicts the wagon driver and a Provincial Correctional Guard dragging a still rain-soaked, motionless Frank Paul from the elevator to the police wagon along the floor of the wagon bay area. After the wagon driver delivered another intoxicated individual in the police wagon to a detox center, Mr. Paul was placed in a nearby alley. Mr. Paul's lifeless body was found at 2:41 early the next morning at that same location.

Historical review of process:

When I took office in February of 2003, the Paul file was one of the most prominent of the many files that awaited the attention of the incoming Police Complaint Commissioner. This file had been the subject of significant media attention during the term of the previous Police Complaint Commissioner and was also a major topic of discussion before the Special Committee to Review the Police Complaint Process. It has been said that the handling of this very case by both the police and the Office of the Police Complaint Commissioner (OPCC) led to a significant loss of public confidence in the police complaint process.

On January 18th, 2002, approximately two years after the Vancouver Police Department (VPD) had imposed a two day suspension on one of the officers involved for discreditable conduct and a one day suspension on the other for neglect of duty, the former Commissioner Don Morrison, communicated his decision by letter. He advised the Chief of the Vancouver Police Department that, in his view, a Public Hearing would not be the appropriate vehicle to address the issues arising from the death of Frank Joseph Paul and that no further action would be taken by the Police Complaint Commissioner. The stated reasons in that letter cited "extended delays" and "other public interest considerations".

In his evidence before the Review Committee on 16 May 2003, the former Commissioner expanded on those reasons stating: "I took the position on Mr. Paul's tragic death that the province would be best served by a process that had a wider scope and a broader focus and allowed for a fuller airing than is possible at a public hearing." He cited other considerations which included *inter alia:* that a *Police Act* Public Hearing is limited to police conduct and cannot examine the duty of care owed by other agencies into whose care people may be released; that police officers are not compellable witnesses under the *Police Act* whereas they are compellable at an Inquest; and that an Inquest would be followed by recommendations for police policies and practices that will help avoid similar deaths or injuries to persons who are detained and released by police. He further indicated that he had written several letters to the Solicitor General recommending both the holding of an Inquest and suggesting a province-wide review of police response to circumstances where they detain or release people who are unable to care for themselves. He also advised the Review Committee that the Solicitor General had declined his requests but agreed to include this issue as the next high risk item for examination in his regular audit of police agencies within the province.

My review of the file indicates that Mr. Morrison indeed wrote to the Solicitor General on 4 October 2001 recommending a province-wide review. By reply on 20 December, the Solicitor General advised Mr. Morrison that he agreed it would be timely to conduct the recommended evaluation under section 50 of the *Police Act* and had requested the Director of Police Services to include the issue as the next high-risk item for examination in his regular audit of police agencies within the Province. On 24 March 2003 I wrote a follow-up letter to the Solicitor General requesting a status update regarding the review. On 15 May 2003 the Solicitor General replied to the effect that they had conducted a preliminary review of the issue and in April 2002 had released the Municipal Police Evaluation of Detention Facilities, but that staff had not yet had the time to undertake a full examination of the issue. To my understanding, to date the matter is still outstanding.

Subsequent to the testimony of various staff members of the former Commissioner's office before the Special Committee concerning the Frank Joseph Paul case during April 2002, the Office of the Police Complaint Commissioner received two "third party" complaints regarding the death of Frank Joseph Paul.

In July 2002, legal counsel on behalf of the family of the deceased requested that the Paul family be provided with a copy of the police jail surveillance video and later in July, the BC Civil Liberties Association requested that the then Acting Police Complaint Commissioner publicize the details of the investigation into the death of Frank Joseph Paul and the actions taken, to prevent the reoccurrence of

such a tragedy. Also in July of 2002, the President of the United Native Nations Society lodged a *Police Act* complaint regarding the death of Frank Joseph Paul.

On September 26th, 2002, Ben H. Casson, QC, the Acting Police Complaint Commissioner, who was appointed in July 2002 following Mr. Morrison's resignation, wrote to legal counsel for the Paul family advising that he lacked jurisdiction to re-consider the decision of the former Police Complaint Commissioner to not order a Public Hearing into the death of Mr. Paul. He also concluded that the *Freedom of Information and Protection of Privacy Act* precluded a copy of the police jail video tape being provided to the Paul family. During the transition of responsibilities when I took office, Mr. Casson shared his ongoing concerns about this file with me and indicated that he had been considering an option of referring the matter to an independent, experienced person to conduct a review of the file and prepare a report on what happened to Mr. Paul.

It was pursuant to this abbreviated history of events that I, as the incoming Police Complaint Commissioner, had to make a determination as to what action would, in my view, be in the public interest.

File review:

After having reviewed the extensive file, the evidence before the Special Review Committee, and having personally viewed the police jail surveillance video depicting the last known moments in the life of Frank Paul, I concluded the family deserved to know the facts concerning Mr. Paul's death in light of conflicting reports the family had received regarding the circumstances of his death. It was my understanding that the family had received differing reports from the police that included one version that Mr. Paul had been the victim of a "hit & run" accident and struck by a taxi cab; and another version that simply advised them that he had died of hypothermia. It was apparent that the family did not know that Mr. Paul had been in police custody at the time of or shortly before his death. Accordingly, on June 20th, 2003, I authorized the release of portions of the police jail surveillance video depicting Mr. Paul's arrival and departure at the Vancouver Police jail on December 5th 1998, to the family's counsel. That video subsequently found its way into the hands of the media and received wide circulation, both on television and selected images in the print media.

In the interim, in early June 2003, my office received new information concerning the circumstances of Mr. Paul's removal from cells hours prior to his death. I assigned a member of my staff, an experienced retired RCMP officer, to follow up that information by conducting an interview with an individual who had new information to provide concerning the incident. That interview also provided the office with additional leads of potential new evidence that needed to be followed up. Accordingly, on June 23rd 2003, I advised Chief Graham of the Vancouver Police Department that I had re-opened the Frank Paul file and requested access

to the Major Crime Section death investigation file, the VPD Internal Section investigation file and all relevant historical arrest booking and release records associated with Frank Paul. I also requested them to identify all guards and officers depicted in the video who had not previously been identified or interviewed.

Lack of Clarity in the Legislation:

Throughout my dealings with this tragic case I have agonized about what was the "right thing to do". Unfortunately, not only are there differing independent legal opinions about whether a Police Complaint Commissioner under Part 9 of the *Police Act* has the power to re-consider the decisions made by the previous Commissioner, but there are also other competing legal and fairness issues at play. One view is that I do not have jurisdiction to re-open a file once a previous Commissioner has made a decision. The other view is that in certain exceptional circumstances, I have the power to do so.

Assuming that I have the authority to make any decisions at all in these unique circumstances, there are many competing interests to be taken into consideration in making a subsequent discretionary determination as to what course of action is appropriate in the public interest.

For the purposes of these Reasons for Decision, I will summarize my understanding of the applicable administrative law that relates to my power as the Police Complaint Commissioner under Part 9 of the *Police Act* to re-open decisions that have been previously made under the Act.

In my view, generally speaking, decisions of the Police Complaint Commissioner are intended to be final and conclusive once made. Although I am unaware of any case law directly on point, my view of the law contained in certain analogous administrative law cases is that arguably, in appropriate circumstances, a tribunal can re-visit past decisions in order to remedy an injustice that cannot otherwise be remedied where the circumstances are extraordinary; the reasons for re-opening are compelling; and where the re-opening is supported by indications in the enabling statute.

Also to be taken into consideration is the fact that in most of those cases the legal proposition is that where a request for re-opening is advanced long after the decision in question has been made, justice may be best served by favouring the finality of the decision-making process, even if a legal case can be made for re-opening.

Unfortunately, the *Police Act* is not clear as to whether or not a Commissioner may re-open previous decisions. I have read a number of independent legal opinions on this issue with differing conclusions. I must therefore rely on my

personal legal interpretation and the exercise of my discretion as to what is in the public interest. Rightly or wrongly, I have concluded that I have the discretion to re-open or re-consider a previous decision in exceptional, compelling circumstances. In my view, that power is inherent in the legislation which requires me to provide effective civilian oversight of the police. The legislature surely did not intend to provide me with a duty, responsibility or obligation without also providing me with the authority or means to carry it out.

Having said that, it must be remembered that the Acting Police Complaint Commissioner, Ben H. Casson Q.C., earlier came to a contrary conclusion having decided that he lacked jurisdiction to re-consider the decision of former Police Complaint Commissioner Don Morrison to not order a Public Hearing into the death of Frank Joseph Paul. In complete fairness, given the uncertainty in the legislation, I cannot find legal fault with Mr. Casson's conclusion. I am simply of a different view. Additionally, the Acting Commissioner did not have the same facts available to him that I do at this time. The subsequent information available to me prompting our re-investigation of certain aspects of the file persuaded me that this case falls into the category of exceptional circumstances providing compelling reasons for re-opening the file.
Having decided that the combination of new information and the unsatisfactory communications with Mr. Paul's family by the VPD dictated that I should re-open the file in the public interest, I instructed members of my staff to review the file. Unfortunately, because of the complexity of the file and due to other pressing matters, I have not been able to formulate my final decision until now.

Once having decided to re-open the file and having conducted a thorough review, I next had to turn my mind to exercising my discretion as to whether or not it was appropriate in all the circumstances to order a Public Hearing. After careful consideration, much deliberation and a weighing of relevant factors, I have come to the reluctant conclusion that for a number of reasons it would not ultimately be in the public interest to now order a Public Hearing under the *Police Act*. In my view, the public interest would be much better served by my recommending other viable alternatives authorized by legislation to provide an open and transparent account of what happened to Mr. Paul on the 6th of December, 1998, and hopefully to prevent such tragic and unnecessary circumstances from ever occurring in the future anywhere in the Province.

CONSIDERATIONS:

Delay
In my respectful view, this case cried out for a Public Hearing to have been called in the first instance when the two officers involved were first assessed their one and two day suspensions respectively by the VPD Discipline Authority. It continues today to cry out for a public airing of the facts, policies, and circumstances that permitted this tragedy to occur.

The *Police Act* is very clear in providing authority to the Commissioner to order a Public Hearing in the first instance where he determines that there are grounds to believe that a Public Hearing is necessary in the public interest[1][1], and requires him to notify the relevant parties within 10 business days after making a decision to arrange or to refuse to arrange for a Public Hearing[2][2]. Now, however, nearly three years have passed since the decision not to arrange for a Public Hearing was made, and more than five years have passed since Mr. Paul's death. That delay has raised a significant legal question as to whether there is now authority to do what ought to have been done earlier.

Family's concerns

Complicating the matter is the fact that Mr. Paul's family residing on the Big Cove Reserve in New Brunswick was not provided with accurate information as to the circumstances leading to Mr. Paul's death. Consequently, they did not file a complaint with the Police Complaint Commission, and did not have the rights and privileges flowing from such a complaint process available to them.

Once apprised of the true circumstances of Mr. Paul's death, the family's reaction seems to me to have been best expressed by the statements of a family member reported in the media to the effect that "*a dog would get better treatment than he got*" and "*I hope with all my heart…that someone will be able to do something about it, look into it anyway, what really happened."*

In my respectful view, although not determinative of the issue, in these unique circumstances the family's concerns are to be given considerable weight in my determination of what is in the public interest. Through their counsel, the family is not seeking a Public Hearing under the *Police Act*. Instead, they are requesting that a Public Inquiry be held and that I exercise my discretion under s.50(3)(f) of the *Police Act* to make recommendations to the Attorney General to hold a Public Inquiry. I have the power to do so if there are reasonable grounds to believe that that the issues are so serious that an inquiry is necessary in the pubic interest or where in my view an investigation, even if followed by a Public Hearing would be too limited in scope. In my view both of those preconditions exist in this case.

Limitations of a Public Hearing under the *Police Act*

There is often confusion in the media and minds of the public as to the nature of a Public Hearing. Too often the terms "Public Hearing" and "Public Inquiry" are used interchangeably. They are not interchangeable. They have both a different focus and a different scope. A Public Hearing under Part 9 of the *Police Act* is called when the Police Complaint Commissioner disagrees with the decision of the Discipline Authority (usually the Chief of Police or his designate) to dismiss a complaint, or alternatively with the type of penalty imposed on an officer who was

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[1][1] See S. 60 (3)(b) and s. 60 (4).

[2][2] See S 60 (6)

found to have committed a disciplinary default. The focus of that Public Hearing is intended to be on the behaviour of the officer(s) and is limited in scope to a particular incident or penalty (or lack of one). The Adjudicator appointed to preside over the Public Hearing has the power to make findings of fact, decide if a disciplinary default took place, and, if so, to impose the appropriate penalty. Thus, the purpose of the Public Hearing is to deal with allegations of misconduct by a particular officer or officers, and has a potentially punitive nature to it. It is limited in scope and therefore usually cannot address concerns about systemic problems within a police force or policing in general in the Province, or general policies governing the way police practices are conducted. There are also limitations on the participation of individuals who may have evidence to give, and limitations on legal standing of certain parties during the course of the Public Hearing.

Legal challenges

Further complicating matters is the fact that essentially for the reasons outlined earlier concerning the legal issues respecting the commissioner's power to revisit previous decisions, to now order a public hearing would undoubtedly result in legal challenges being raised in court by the police, the respondents, the police union and any other party who may be affected by my decision. Those challenges would undoubtedly be protracted, with a potential of ultimately reaching the Supreme Court of Canada, and based on my experience, could take another three years to resolve. It would not be in either the interest of the family, the complaint process or the public interest to further delay these proceedings because of legal challenges to my authority under existing legislation. In addition to the legal challenges to my authority to re-open the case, I could anticipate potential common law legal arguments of *res judicata*, issue estoppel, double jeopardy, abuse of process based on delay, and challenges under the *Canadian Charter of Rights and Freedom.*

Practically speaking, not only would the time delays be adverse to the public interest, but the cost of litigation does not warrant embarking upon such a course of conduct. The public interest includes many aspects and cost to the taxpayers as a factor cannot be overlooked as a proper consideration.

Finality and fairness

As I have stated earlier, there is another legal consideration that dictates against ordering a public hearing at this stage – one of finality and fairness. It must be remembered that although I disagree with the minimal penalty imposed by the discipline authority against the two officers involved, they did "serve their sentence" so to speak. Regardless of how inadequate I deem their one- and two-day suspensions to be for their actions, at law there has to be a reasonable finality to the complaint process under the *Police Act*. To now, approximately three years later, put them again in jeopardy for an increased penalty under the *Police Act* that they had thought was behind them, may violate the fundamental principle of fairness, and contravene the administrative law concept that there

must be some degree of finality. Unlike a Coroner's Inquest or a Public Inquiry, a Public Hearing under the *Police Act* focuses on imposing corrective measures or discipline on officers found to have committed a disciplinary default. These two police officers had already been dealt with and had their punishment imposed. Therefore, in all of the circumstances, this consideration also militates against now ordering a Public Hearing.

ALTERNATIVES:

Once having decided that a Public Hearing under the *Police Act* at this stage of the proceedings is not appropriate for the aforementioned reasons, I next turn to the available alternatives that have both the legislated mandate and the proper scope to address many of the concerns raised by the Paul incident.

I initially considered the option contemplated by Mr. Casson of hiring an independent person of impeccable qualifications and standing in the community to conduct a review of the file and to prepare a report to our office outlining that individual's findings and recommendations. The difficulty with that option was that such an individual would not have the legislated powers of summons or subpoena to have access to the kind of information necessary to prepare a report that was comprehensive in scope. Such a report would be based on available evidence and would have to rely on total co-operation of all individuals and agencies who may have information material to the matter. Nor would any recommendations flowing from such a report have any binding legal effect. Additionally, there is no provision under the present legislation which contemplates that route as an option. The Police Complaint Commissioner seems to be limited to arranging a Public Hearing – not hiring an independent person to conduct an inquiry and publishing a report.

On balance therefore, in my respectful view, the public deserves to have a thorough public airing of the circumstances, in a process whereby the decision-makers have legal access to all the relevant information, supported if necessary by subpoena and summons powers. I next turned to the consideration of two other options:

1. A Coroner's Inquest under the *Coroner's Act*:

At the outset, it must be pointed out that a Coroner's Inquest with a jury was never held in this case. Instead, the Coroner's office issued a Judgment of Inquiry authored by the Vancouver Regional Coroner.

Pursuant to s. 10 of the *Coroner's Act* an inquest is mandatory where there is a "death in the circumstances referred to in section 9(3)".

Section 10 states:

> *The coroner **must** issue a warrant to hold an inquest in the case of a death in a police prison or lockup or of a death in the circumstances referred to in section 9 (3).*

Section 9(3) states:

> *If a person dies while **detained by or in the actual custody of a peace officer**, the peace officer must immediately notify the coroner.* [Emphasis added]

It is my understanding that such a mandatory Coroner's Inquest was not held because of the Coroner's view that this was not technically an "in-custody" death. The Coroner in coming to that determination obviously relied on the facts contained in what I now deem to have been an incomplete and therefore flawed investigation. In fairness to the Coroner, their office at the time of making their determination not to hold an Inquest, did not have the benefit of two vital pieces of information - Dr. Ferris' report that, among other things, indicates that Frank Paul may well have died in the police wagon itself; and the most cogent piece of evidence-the surveillance video. Nor did the Coroner have the benefit of highly relevant new evidence obtained by my office since we re-opened the file.

In my respectful view the circumstances by which Mr. Paul was deposited in the alley and allowed to succumb to hypothermia indicate that arguably he never left police custody. In his condition, he was unable to look after himself. He was in police custody once they brought him into the police station. He remained in their custody when they dragged him in a helpless state into the police transport. The police officers dealing with Mr. Paul that night had a duty of care towards him.

In addition to the duties of care defined over many years in our common law, the VPD has its own policy manual establishing the duty of care owed by its officers to persons like Mr. Paul.

That duty of care is set out in a number of sections in their Policy Manual. They are as follows:

Section 13.1 (Code of Ethics). That section provides, among other things:

> *As a member of the community and as a police officer, I recognize that my fundamental duty is to protect lives…and be constantly mindful of the welfare of others…. I will preserve the dignity of all persons…. I will honour the obligations of my office and strive to obtain excellence in the performance of my duties.*

Section 77.2(1) states:

> *members shall be responsible… for the safe custody, at all times, of …*
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> *(a) (a) persons arrested by them;*
> *(b) (b) persons guarded by them; and*
> *(c) persons escorted by them.*

Section 128.1 (Arrest-hold State of Intoxication in a Public Place) reads:

> *(1) (1) only those persons who are intoxicated by alcohol or a drug to the extent that they are unable to care for themselves will be arrested….*
>
> > *(b) intoxicated persons who are found to be medically questionable, injured, ill…must be sent to the hospital. Members are advised that the individual may be unable, given the nature of his injuries or degree of intoxication, to make rational decisions with respect to medical treatment….*
>
> *(4) non-violent persons arrested shall be taken to the designated detox center located at 377 E. 2nd Avenue.*

Mr. Paul was at their mercy as to where he would be taken. Whether they lodged him in cells, took him to a detox facility, or dumped him in the alley was not within his control. He had no say in the matter, and had no ability to affect his situation. Had they taken him in that condition to either a detox facility or to hospital, he would have been turned over to others who had a duty to care for him. Arguably, by dumping him in an alley, the police did not turn over his care to anyone else. They continued to be responsible for his care since he was incapable of caring for himself. In that sense, he remained in their custody, albeit not in a traditional location.

A similar reasoning process drives one to the conclusion that he had also been "detained by…a peace officer" and therefore also met the preconditions in s. 9 (3) to make the holding of an Inquest mandatory. Additionally, it is significant to note that the police themselves referred to this matter in all of their investigations as an "in custody" death. The file cover report received by our office from the VPD reads: 'SUDDEN DEATH (IN CUSTODY)". Hence, for all of those reasons in my view, the Coroner ought to consider this to be an in-custody death and be governed by the mandatory duty to hold an Inquest.

If I am wrong about the determination as to whether Mr. Paul was "detained by a peace officer" or "in custody" and therefore holding an inquest was not mandatory, then in my respectful view, the Coroner still had a residual discretion to hold a Coroner's Inquest pursuant to section 18 of the *Coroner's Act.* The

circumstances of Mr. Paul's death, including factors of the VPD policy of "breaching", the fact that Mr. Paul was a member of a marginalized group of individuals residing in the Vancouver downtown East end, and the fact that the VPD had decided that the officers involved had committed disciplinary defaults warranting suspensions to be issued, could have provided the Coroner with ample reasons to conduct a Coroner's Inquest.

Instead of calling a Coroner's Inquest, the Coroner decided to conduct an Inquiry without a Jury pursuant to s. 20, and ultimately issued a Judgment of Inquiry on 8 November 1999. The Coroner concluded that the immediate cause of death was hypothermia due to exposure/alcohol intoxication and classified the death as accidental. The Coroner also made certain recommendations involving staff education at the Vancouver jail and amendments to the policy manual and record keeping. The Coroner made these recommendations because of "a series of non-medical judgments and lack of clear policy"(by the VPD).

It is tangentially of interest that the recommendations contained in the coroner's 8 November 1999 Judgment of Inquiry are directed to the Vancouver City Police Corrections located at 312 Main Street. Arguably, those recommendations are limited to that institution. The problem is that the VPD jail facilities were moved from 312 Main street to the Provincial Remand Centre at 222 Main Street on 22 August 1999.

Since that date all remanded persons in custody at that facility are under the jurisdiction of the Provincial Corrections Department and hired by the provincial government. Arguably, the coroner's recommendations were directed to an institution that no longer existed.

Section 20(5) of the *Coroner's Act* states:

> *(5) A person may apply to the chief coroner to have an inquiry reopened on the grounds that new evidence has arisen or has been discovered after the coroner's report is forwarded to the chief coroner under subsection (4).*
>
> *(6) The chief coroner may direct that the coroner reconsider the matter if the chief coroner considers that the evidence referred to in subsection (5)*
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> > *(a) is substantial and material to the inquiry, and*
> >
> > *(b) did not exist at the time of the inquiry or did exist at that time but was not discovered and could not through the exercise of due diligence have been discovered.*

One option would be for me to make an application to the Chief Coroner to re-open this matter and request the Chief Coroner to hold a Coroner's Inquest.

Such an application would include a request that the Chief Coroner revisit the circumstances and make a fresh determination as to whether this was a "detention by a peace officer" or an "in custody" death requiring a mandatory Inquest to be held. It would also provide the Chief Coroner with the information that would enable the Chief Coroner to conclude that the new information and evidence is substantial and material to the inquiry and permit the Chief Coroner to make a discretionary decision under s.18 that an inquest is necessary. However, my first option of making an application to the Chief Coroner to hold a Coroner's Inquest at this time, is not the optimal means to comprehensively deal with the problems raised by the Paul file.

Coroner's Inquest not the best option in all of the circumstances:

Although holding a Coroner's Inquest would be better than nothing at all, in my view it is not the best option. At the outset, a Coroner's Inquest would be limited to having the jury "inquire into who the deceased was, and determine how, where and by what means he or she died".[3[3]] Such an Inquest is not mandated to determine "why" such a tragedy occurred or, the conduct of the police investigation that followed.

In order to fully appreciate the limitations of a Coroner's Inquest in similar circumstances, it is relevant to consider and briefly discuss some recent and ongoing Saskatchewan experiences that are directly on point.

The Saskatchewan incidents:

To date, no less than five incidents over the last 13 years have recently come to light involving four deaths and one near death of aboriginal or Metis men in the Saskatoon area. To understand the significance of these events to the Paul case considerations, a brief historical analysis would be of assistance.

On 29 November 1990 a 17 year old Neil Stonechild was found frozen to death in a remote field on the outskirts of Saskatoon in –28 C temperatures. His family alleged foul play by police. A police investigation concluded in 1991 ruling his death as accidental. No inquiry into his death was called at that time.

Ten years later, on 19 January 2000, 53-year old Lloyd Dustyhorn was found frozen to death in Saskatoon. He had been taken into police custody the night before for public intoxication.

Darrell Night alleged that nine days later, on 28 January 2000 police officers picked him up for no reason and drove him to the outskirts of Saskatoon in –22 C weather, wearing only a jean jacket and summer shoes and left him there. He survived his ordeal to later tell the story that resulted in a subsequent investigation into other similar incidents.

[3[3]] See S 27(1) Coroners Act

The next day, 29 January 2000 Rodney Naistus, 25, was found frozen to death without a shirt in the same area where Night had been abandoned the day before, an industrial area near the Q.E. power station in Saskatoon.

A few days later, on 3 February 2000 Lawrence Wegner, 30 was found frozen to death wearing only a T-shirt, jeans and socks, near the same power station in Saskatoon.

The next day, on 4 February 2000, Darrell Night came forward to allege that police officers had "kicked him out of a police cruiser" the previous week, 28 January.

Saskatoon Police Chief, Dave Scott ordered an investigation the same day. On 10 February 2000 two Saskatoon police officers, Hatchen and Munson were suspended with pay after they admitted to picking up Night and driving him to the outskirts of town. On 16 February 2000, Chief Scott requested the province to appoint RCMP investigators and that request was granted.

It is important to note that this apparent practice of removing individuals from a location within the city to remote areas outside the city are referred to in Saskatchewan as "starlight tours". A similar practice in British Columbia, as in this case, is referred to as "breaching outside the area".

After the conclusion of the RCMP investigation into Night's allegations, on 10 April the two Saskatoon police officers, Hatchen and Munson were charged with unlawful confinement and assault. They were ultimately convicted and sentenced to 8 months jail. Both conviction and sentence were upheld on appeal. It must be remembered that this sentence was for an incident where the victim did not die.

Of particular significance to my deliberations is the fact that a Coroner's Inquest was held into each of the deaths of Lloyd Dustyhorn, Rodney Naistus and Lawrence Wegner between May 2001 and February 2002. To my understanding, the First Nations and Metis communities were dissatisfied with the process under their Coroner's Act because the inquests did not answer two of the most fundamental questions – in effect, "why did this happen?" and "was race an issue?".

Apparently as a result of the aboriginal community's dissatisfaction with the *Coroner's Act* process and the unresolved facts of the Stonechild case (1990), on 20 February 2003 Saskatchewan's Justice Minister, Eric Cline called an inquiry into the death of Neil Stonechild, appointing Mr. Justice David Wright as Commissioner of the inquiry. It is important for the purposes of my Reasons to note that among the terms of reference given to the Commissioner was that he "**will have the responsibility to inquire into any and all aspects of the**

circumstances that resulted in the death of Neil Stonechild, and the conduct of the investigation into the death of Neil Stonechild…."

That inquiry commenced on 8 September 2003 and is currently ongoing.

2. A Public Inquiry under the *Inquiry Act*

Having outlined my concerns with the limitations of proceeding with the Paul case under the British Columbia *Coroner's Act* process, and having outlined what Saskatchewan officials ultimately decided to do, I am of the view that that the public interest dictates that I should recommend to the Attorney General that he order a Public Inquiry into the Paul matter, pursuant to my mandate under S.50(3)(f) of the *Police Act*.

It must be remembered that Mr. Paul died in 1998. Mr. Stonechild died in 1990, nearly 13 years ago. Therefore, the passage of time alone does not prohibit the calling of a Public Inquiry at this stage.

A Public Inquiry has a much broader scope than a Coroner's Inquest. It can *inter alia* look into the way certain police practices and policies are conducted and make recommendations for province-wide application, not just one police force. A Commissioner appointed under the *Inquiry Act* has much wider powers including the power to summon witnesses, enforce the summons and punish for contempt, and report the findings to the Lieutenant Governor in Council. By contrast, although Commission counsel conducting a Public Hearing under the *Police Act* has the power to summons certain witnesses, counsel has no power to compel the most important witnesses, ie. the Respondent police officers, to testify.

Under the *Police Act*, the Police Complaint Commissioner has the power to:

50(3)(f)	*make recommendations to the Attorney General for a public inquiry under the Inquiry Act if there are reasonable grounds to believe that:*
50(3)(f)(i)	*the issues in respect of which the inquiry is recommended are so serious or so widespread that an inquiry is necessary in the public interest;*
50(3)(f)(ii)	*an investigation conducted under this Part, even if followed by a public hearing, would be too limited in scope, and*
50(3)(f)(iii)	*powers granted under the Inquiry Act are needed.*

In my respectful view, the issues in the Paul case are so serious that an inquiry is necessary in the public interest, and an Inquiry under the *Inquiry Act* at this late date is best suited to arrive at the truth and make recommendations for future conduct. Those recommendations would not necessarily be limited to the policies

and practices of the Vancouver Police Department, but may have province-wide or even country-wide benefits.

It must be noted that although I have the power to arrange for a Public Hearing under the *Police Act*, I do not have the power to order a Public Inquiry under the *Police Act*. I merely have the power to recommend such a Public Inquiry to the Attorney General if, in my view, the preconditions listed above are present.

In my respectful view, this is the preferred option for resolving this outstanding issue. Both the Coroner and the Attorney General have ongoing jurisdiction to deal with the matter without risking further legal challenges to their right to call either a Coroner's Inquest, or an Inquiry. As I mentioned earlier, at this late date, given all that has happened in the interim, a decision by me to call a Public Hearing under the *Police Act*, is undoubtedly going to be challenged, result in further delays and, if those challenges are successful, may ultimately result in no public airing of the circumstances of Mr. Paul's death being held.

The Attorney General also has jurisdiction to order that an Inquest be held pursuant to s. 23(3) of the *Coroner's Act* in certain situations. Accordingly, I propose to provide as soon as practicable a copy of relevant materials directly to the Attorney General for his consideration with the strong recommendation that he order a Public Inquiry.

CONCLUSION:

For all of the above reasons, I have reluctantly concluded that although I have deemed it in the public interest to re-open the file and have it further investigated, that it would in all of the circumstances not be in the public interest for me at this late date to order a Public Hearing under the provisions of the *Police Act*.

Instead, I have concluded that it is much more likely that the public interest would be best served by providing the Chief Coroner and the Attorney General with the results of our investigation, the new evidence that came to light, along with documentation and video evidence that became available only after the decision by the Coroner not to hold a Coroner's Inquest. It is my sincere hope that the Chief Coroner and the Attorney General who each have ongoing jurisdiction to deal with this matter under various statutes will be persuaded by the evidence to conduct either a Coroner's Inquest or a Public Inquiry. For the reasons given, of those two options, a full Public Inquiry under the *Inquiry* Act is preferable and recommended.

Dirk Ryneveld, Q.C.
Police Complaint Commissioner

Victoria, B.C.
16 January, 2004
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