OFFICE OF THE
POLICE COMPLAINT COMMISSIONER

British Columbia, Canada

REASONS FOR DECISION

PUBLIC HEARING REQUEST REGARDING THE OAK BAY POLICE INVESTIGATION INTO FATAL MVA

Summary of Incident

On September 28, 2003 a tragic event happened in Oak Bay. At approximately 2:40 am that day, 21 year old woman (HM) was returning by cab to her apartment on Oak Bay Avenue. She directed the cab driver to stop and let her off just past Mitchell Street on the south side of Oak Bay Avenue. Her apartment was located directly across the street from where the cab was stopped. Investigation revealed that Ms HM got out of the cab by way of the passenger side rear door, apparently walked behind the vehicle, and began crossing the street where there was no crosswalk when she was struck by an oncoming taxicab traveling westbound on Oak Bay Avenue. Emergency personnel arrived very quickly, but Ms HM was pronounced dead later that morning at the hospital as a result of her injuries.

Oak Bay Police investigated the fatal motor vehicle accident with the assistance of a Collision Analyst and a Collision Reconstructionist from the Saanich Police Department, and the Victoria Police Forensic Identification Section. On April 20, 2004, a Report was forwarded to Crown Counsel for review, but not specifically recommending charges. On August 3, 2004, the Crown determined that no charges would be forthcoming against the driver of the taxi who had struck the pedestrian.

***Police Act* Proceedings**

On April 6, 2005, my office received a Form 1 Record of Complaint from the parents of HM (hereinafter referred to as the Complainants).

The Complainants' 7-page complaint (with 44-pages of attachments) listed their concerns regarding the quality of the investigation conducted by the Oak Bay Police Department.

Listed as potential respondent officers were Sgt DM (the primary investigator), Cst IC (exhibit officer) and Chief Constable Andersen. According to the *Police Act*, complaints concerning a Chief Constable must be forwarded to the Police Board of that department and investigated by a Chief Constable from another municipal force. After reviewing the Complainants' record of complaint and attachments, our office concluded that Chief Andersen may not appropriately be designated as a Respondent in this matter. The file was sent to Chief Constable Paul Hames of the Central Saanich Police Service, for an external preliminary review to determine who the appropriate respondent officers would be. If it was determined that Chief Andersen should be included as a respondent, the file would then be sent to the Oak Bay Police Board for assignment of an external investigating Chief Constable.

On May 10, 2005, Chief Hames determined that the appropriate respondent officers to the complaint were Sgt DM and Sgt IC (then Constable). He confirmed that Chief Andersen's involvement was simply as a result of his position as Chief Constable for the Oak Bay Police Department and that he did not have any direct involvement with the investigation in question. He did, however, recommend that Chief Andersen consider having the matter investigated by an external agency given the Complainants' loss of confidence in the Oak Bay Police Department generally.

Chief Hames also determined that, in addition to the Public Trust aspect of the complaint, five of the questions raised related to departmental issues. This warranted a Service or Policy component to the complaint, making it a compound complaint.

As a result, Chief Andersen formally requested that a senior investigator with the Central Saanich Police Service be assigned the investigation of the Public Trust component of the complaint. The Service or Policy portion of the complaint was properly referred to the Oak Bay Police Board.

On May 26, 2005, Notices of Complaint were completed for Sgt IC alleging the potential disciplinary default of Neglect of Duty; and to Sgt DM alleging the complaints of Discreditable Conduct, Neglect of Duty and Deceit. Our office confirmed the compound characterization on May 31, 2005.

Also on May 31, 2005, Ms. Dyck, the Sr. Investigative Analyst assigned to this file on behalf of our office, sent a letter to the Complainants explaining the process involved in the handling of their complaint and the reasons why Chief Andersen was not included as a respondent. The Complainants responded by letter dated June 4, 2005, advising that they did not agree with the decision not to include Chief Andersen as a Respondent and attached documentation that, in their opinion, showed the involvement of Chief Andersen. Ms. Dyck reviewed the materials and, in her opinion, Chief Andersen's involvement was limited to meeting with the Complainants and responding to their correspondence after the investigation was completed. While the Complainants were obviously not happy with the explanations provided by Chief Andersen, there was nothing contained in the correspondence that could constitute a disciplinary default on the part of Chief Andersen. Ms. Dyck replied to the Complainants, confirming the earlier decision to proceed with the complaint against Sgt DM and Sgt IC and advised that if during the course of the investigation, Sgt RM (the assigned investigator) discovered

evidence that suggested possible misconduct by Chief Andersen, he could be added as a respondent at any time. The subsequent investigation did not uncover any evidence warranting the designation of Chief Andersen as a Respondent.

Sgt RM completed his investigation and wrote a comprehensive Final Investigation Report that attempted to address all of the Complainants' questions that had during the course of the investigation grown from 9 to 40 questions. In summary, Sgt RM concluded the following:

> *The Public Trust default of Neglect of Duty is supported by the evidence. Sgt DM failed to interview or direct another police officer to interview, two critical witnesses at the time of the incident so as to obtain important details surrounding the event. These witnesses were then found to have changed their version of the events five days later. Sgt DM also failed to formally interview Mr. S whose witness evidence contradicted the testimony of five independent witnesses. Sgt DM also failed to document in the master file or in his police notebook the re-enactment of October 3rd, 2003 and included the information obtained in the re-enactment as factual evidence in the Report to Crown Counsel. Finally, Sgt DM failed to include in the Report to Crown Counsel new information (Addendum) provided by the Traffic Analyst and failed to ensure this critical piece of information was forwarded and reviewed by Crown Counsel.*
>
> …
>
> *Sgt. IC failed as the exhibit officer, to properly document and account for pieces of physical evidence that formed part of the conclusions reached by the Traffic Analyst.*[1]

Sgt RM did not make any recommendations regarding disciplinary or corrective measures. He did however made the following general recommendations:

1. In the event that a Supervisor becomes the primary investigator in a major investigation, the file should be reviewed by the Deputy Chief of Police frequently to ensure all aspects of the investigation have been completed and documented.

2. If a Supervisor is the primary investigator and submits a Report to Crown Counsel, the report should be reviewed and approved by the Deputy Chief of Police or another Supervisor prior to it being forwarded to Crown Counsel.

3. The Oak Bay Police Department should give consideration to purchasing small handheld tape recorders for the patrol members. This would afford them the opportunity to take audio taped witness statements from multiple witnesses at an incident if the opportunity presents itself. The officer can ask for clarity on any areas of ambiguity at the time of the incident rather than

[1] Investigation Report, p.68

wait for the witness to complete a written statement at a later date which may require follow-up interviews.

4. The Patrol Supervisor should carry a camera inside his police vehicle at all times as s/he will be responding to all serious incidents. The scene can be photographed in its original state even if other support services (such as a Traffic Analyst) are called to assist. The photographs can be used to confirm the location of evidence and to supplement memory recall as the investigation continues.

Discipline Authority's Decision re Public Trust

In his capacity as Discipline Authority concerning discipline defaults of members of the Oak Bay Police, on November 30, 2005 Chief Andersen delivered his decision. He found that the evidence substantiated the disciplinary default of Neglect of Duty against both Sgt DM and Sgt IC, pertaining to their note taking and documentation with respect to the handling and continuity of file exhibits. There was no evidence to support the allegations of Discreditable Conduct or Deceit on the part of Sgt DM. The proposed corrective/disciplinary measure was a Verbal Reprimand. A Pre-Hearing Conference was offered to both respondents.

Chief Andersen also forwarded an unedited copy of Sgt RM's 76-page Final Investigation Report to our office, the Respondents and to the Complainants.

On November 30, 2005, a Pre-Hearing Conference was held with Sgt IC, at which time he admitted responsibility for the default and accepted a Verbal Reprimand. Sgt DM requested time during which to prepare a rebuttal to the findings by Sgt RM. Sgt DM's submissions dated December 30, 2005, responded to criticisms by Sgt RM, specifically those relating to his analysis of Mr. S's statement and "inaccuracies" contained in the Report to Crown Counsel. Sgt DM, however, did not dispute the finding that his documentation regarding the seizure and handling of exhibits was poorly done and at his Pre-Hearing Conference held on January 4, 2006, Sgt DM acknowledged responsibility for the default and accepted a Verbal Reprimand. It is important to note that a verbal reprimand is a formal form of discipline or corrective measure and results in a written document outlining the fact that a verbal reprimand was given to the officer. That document forms part of the officer's service record.

Sgt DM submitted to Chief Andersen on January 30, 2006, an "Addendum" to his earlier submissions, identifying errors in Sgt RM's report. Sgt DM requested that:

> *… the Police Complaint Commissioner consider my Response to the Investigation Report by Sgt RM dated 30 December 2005, and this addendum, and conclude that findings outlined on page 68 of his Investigative Report are incorrect and the Public Trust defaults of Neglect of Duty as alleged by Sgt. RM are not supported by the evidence. Likewise, his belief that "there was a degree of neglect in this instance that was more than a mere performance deficiency, rather it crossed into misconduct" from the points numerated on*

page 18.[2] *I believe that I have dealt with these in my responses and shown clearly that there was no neglect of performance and certainly nothing that crossed into misconduct.*

The writer also requests that should such disciplinary defaults be determined to be not substantiated by the Police Complaint Commissioner that either I be exonerated on these allegations or a new investigation be ordered.[3]

Should I be exonerated I request that the Disciplinary Authority, Chief Constable Andersen, then rescind the disciplinary action of Verbal Reprimand against Sgt DM in this matter so that his name may be cleared of a finding of Neglect of Duty which crosses into misconduct. … I do not believe that such neglect existed in this matter and contend that such neglect was not proven.[4]

According to section 58(7):

Disciplinary or corrective measures accepted by a respondent and approved by the discipline authority at a pre-hearing conference constitute a resolution of the matter and, unless a public hearing in respect of the complaint is arranged by the police complaint commissioner, the resolution is final and conclusive and is not open to question or review by a court on any ground.

Sgt DM accepted Chief Andersen's decision and imposition of a Verbal Reprimand at a Pre-Hearing Conference and therefore does not have the right to request a Public Hearing. However, his comments are to the effect that he is not disputing Chief Andersen's decision – neglect of duty with respect to the keeping notes and proper documentation regarding exhibits. Sgt DM is merely disputing the conclusions contained in Sgt RM's report that did not form part of Chief Andersen's decision, nor were factored into the discipline imposed.

Decision of Oak Bay Police Board re Service or Policy

As stated earlier, the Service or Policy component of this complaint was referred to the Oak Bay Police Board. Prior to the Complainants lodging a *Police Act* complaint, Chief Andersen was well aware that there were concerns regarding the quality of the Oak Bay Police Department's handling of the investigation into HM's death. As a result, Chief

[2] **1)** Sgt DM failed to interview, or direct an officer to interview, a potential suspect on September 28, 2003; **2)** Sgt DM failed to record in his notebook or on an occurrence report information pertaining to conversations he had with Mr. D and Mr. S on October 3rd, 2003; **3)** On October 3rd, 2003, Sgt DM failed to document the re-enactment in his notebook or on an occurrence report to be reviewed by senior officers; and **4)** Sgt DM failed to re-interview Mr. S when it was clear that his statements both verbal and written contradicted independent witnesses and toxicology results.

[3] It must be noted that Sgt DM was mistaken about the mandate of the Police Complaint Commissioner. The Police Complaint Commissioner is not authorized to "unsubstantiate" a complaint once it is substantiated by the Discipline authority. Under the statute, if the PCC disagrees with the DA, his only option is to arrange for a public hearing (if he deems it in the public interest to do so) to enable an independent adjudicator to determine what the ultimate decision should be.

[4] Sgt DM's "Addendum", dated January 30, 2006, p.6

Andersen requested a Level 4 Collision Reconstructionist with the RCMP Island District Traffic Services be assigned to review the entire Oak Bay Police investigation file to identify any deficiencies and make any needed recommendations. RCMP Cpl Dagg was assigned to review the file and on April 26, 2005, delivered his report. Cpl Dagg's report was forwarded to the Oak Bay Police Board and formed the basis for their decision and recommendations.

On June 28, 2005, Mr. Cochrane, Secretary of the Oak Bay Police Board, wrote to the Complainants advising them that the Board has accepted the findings of Cpl Dagg's report and adopted the following recommendations:

1. Consideration should be given to using a dedicated team approach for the investigation of serious motor vehicle accidents.

2. Regardless of the approach to the investigation, more emphasis should be placed on taking detailed, timely and informative statements.

3. Consideration should be given to using a different system for organizing large files of this nature, which would give the file coordinator more control of the file and contribute to a more focused investigation.

4. Collision reconstruction or technical analysis reports should contain more detail than was presented in this case. In particular, the key background data from which conclusions are drawn should be included, so that the reader has in a single document the answers to questions that might arise in the absence of that information.

The Board directed Chief Andersen to develop a revised accident investigation policy or protocol reflecting these recommendations. Once the Board has reviewed and accepted Chief Andersen's revisions, a copy of the amended policy would be forwarded to the Complainants. On September 21, 2005, the Board released the department's amended "Traffic Collisions/Motor Vehicle Incidents" policy, as approved by the Board on September 20, 2005, with copies sent to the Complainants, the Director of Police Services, Chief Constable Andersen and to my office.

Request for review From the Complainants

On September 29, 2005, our office received correspondence from the Complainants, stating:

> *We as the complainants, are not satisfied with the amendments made to the policy, nor, are we content that this response concludes their obligations to the Service & Policy portion of our complaint, and as such, we request a review by the office of the Police Complaint Commissioner.*

Upon review of the file with respect to the Service & Policy component of this complaint, I am satisfied that the Board's decision and action are appropriate and adequate.

The Role of the Complainants

It is not my intention to in any way diminish the emotional suffering and trauma the Complainants have experienced. Unless a person has experienced a similar loss of a child, I do not believe the depth of their suffering can be fully understood. However, the expectations of grieving parents will rarely be satisfied by the outcome of a police investigation that does not result in charges against the person they believe to have been at fault for their tragic loss. Sometimes, tragic accidents are just that - accidents.

Beginning on the date the accident occurred, it is clear that the Complainants wished to be active participants in the police investigation and the Oak Bay Police Department tried to accommodate them by meeting or having contact with them on a daily basis. Nevertheless, there were a series of unfortunate incidents at the beginning of the investigation that I believe set the tone for the Complainants' loss of confidence in the Oak Bay police investigation:

- One of HM's boots was not recovered at the scene by the police. On impact, it had flown off and lodged in a tree by the road. The boot fell out of the tree approximately 7 hours after the police had departed the scene and was found by a friend of HM's, who turned it over to the Complainant who, in turn, delivered it to the police.

- The Complainants also located a side mirror from the Empress Taxi that was left behind after the Traffic Analysts from the Saanich Police had completed their examination and left the scene. This also was delivered to the Oak Bay Police by the Complainants.

- Certain comments attributed to the Coroner appeared to be critical of the Oak Bay investigation of the incident. Such comments, if made, did nothing to enhance confidence in the investigators or in the Oak Bay Police Department's handling of the investigation in the eyes of the grieving parents.

The investigators and senior Oak Bay officers met with the Complainants often in order to explain how the investigation was proceeding and answered their many questions. Within the 30 days following the accident there were 10 documented meetings between the Complainants and the Oak Bay Police. Although the Oak Bay Police had tried to accommodate their concerns, it became apparent the Complainants were not satisfied with the course of the investigation. Regardless of my views concerning the thoroughness of the initial investigation at the scene, Oak Bay Police cannot be faulted for the way in which they dealt with the Complainants after the fact. From the materials I have reviewed, they were exceptionally sensitive, forthcoming and open.

Previous Reviews of Oak Bay Police File in the accident

In addition to the review conducted by my office, the investigation conducted by the Oak Bay Police Department into the fatal motor vehicle accident involving HM has been the subject of four previous external reviews:

1. Review by Crown Counsel

Mr. Steve Salmond, Administrative Crown Counsel for the Victoria Crown Office, initially reviewed the Report to Crown Counsel submitted by Sgt DM. Mr. Salmond requested additional materials and on May 31, 2004, a supplemental binder with the requested documents was sent to Crown Counsel.

Mr. Salmond subsequently discussed the file with Sgt RM. Sgt RM summarized a conversation with Mr. Salmond as follows:

> *Mr. Salmond added that after reviewing the totality of the evidence, he concluded that there was insufficient evidence to support a criminal charge or a charge under the Motor Vehicle Act.*[5]

Following the Crown's decision to not proceed with charges, a meeting was held between Mr. Salmond, the Complainants, and Sgt DM, to explain why the Crown would not be laying charges against Mr. D. The Complainants were very upset and it was subsequently agreed that the file would also be reviewed by both Ms. Christine Lowe, Deputy Regional Crown Counsel, and by Mr. Derrill Prevett QC, a senior prosecutor with the Nanaimo Crown Counsel office. Both Ms. Lowe's and Mr. Prevett's reviews upheld the original decision by Mr. Salmond that charges were not appropriate in these circumstances.

2. Review by Cpl Dagg, RCMP

As mentioned earlier, in February 2005, prior to the Complainants filing a complaint, Chief Andersen requested that a Level 4 RCMP Collision Reconstructionist be assigned to review the entire Oak Bay Police investigation file. Cpl Dagg was assigned to review the file and on April 26, 2005, delivered his report. As stated in his opening paragraph, the purpose of the review:

> *… was not to do a reconstruction of the file but was to examine how the investigation was handled to learn if there were areas where mistakes were made or if there were areas of the investigation that might have been addressed more successfully.*[6]

[5] Sgt RM's Investigation Report, p. 34
[6] File Review by Cpl Dagg, 2005-04-26, p. 1

Specifically with respect to the investigation conducted by Sgt DM and Sgt IC, Cpl Dagg makes the following observations regarding the management of the scene:

> *Three members attended the scene. The scene was contained and a number of witnesses were identified. An important piece of evidence, the cab which had brought the pedestrian to the scene, had left before the members' arrival. Two pieces of evidence, a purse and a parked car, were moved before their exact locations could be marked.*
>
> *The purse had been moved by a friend of the pedestrian. This was not a malicious action. She replaced it as closely as possible to its original location as soon as it came to the attention of the members. While the location of the purse was of some value in the investigation, its exact position was not critical.*
>
> *A parked vehicle was moved from the scene before its location was marked. The exact position of this vehicle may have been of some assistance to the investigation but that fact is likely to have been more apparent to the Reconstructionist than it was to the on scene investigators.*
>
> *One of the pedestrian's boots fell from a fully leafed tree onto the roadway approximately seven hours after the crash. It is not difficult to understand how the boot was not found. It was in a tree, well above street level in a very dark area that one would not normally expect to find evidence…*
>
> *While it would be nice to have identified and located the three items detailed above it is not difficult to understand how they were missed. There were only three members at the scene. They were dealing with a serious crash with eight or more witnesses on site in addition to ambulance attendants and fire department personnel.*[7]

Overall Cpl. Dagg identified in the Oak Bay Police investigation three general areas of weakness:

1. The statements taken from the direct participants were too brief and covered only the basics of the event. There were not sufficient follow-up interviews conducted to clarify details or seek additional information. In addition, witness statements should have been obtained in a more timely manner, as some were only prepared and delivered to the police department one to two weeks following the accident.

2. Cpl Dagg attributes part of the blame for this lack of timely and thorough follow-up with witnesses to the fact that there were not sufficient resources allotted to the investigation. Cpl Dagg acknowledges that:

[7] File Review by Cpl Dagg, pp 1-2

> *It is very difficult to provide full attention to any investigation when the process is constantly being interrupted by the need to attend to other matters. It does appear that the investigators made every effort to put in as much time as possible on the file but it is also obvious that resources dedicated to the investigation would have been much more successful in both obtaining more information and in obtaining that information in a more timely manner.*[8]

3. Cpl Dagg agreed with the conclusions reached by Cst Gurzinski in his Collision Analyst & Reconstructionist Report:

> *The conclusions drawn by Cst Gurzinski are drawn from the available physical evidence and what I believe to be reasonable assumptions. While those assumptions might be argued with, they fit well with the physical evidence. His conclusions as to the cab's minimum speed is reasonable and fully supported. I think that the point of impact would have been better described in more general terms as near the centre line and probably with the best interpretation of the physical evidence putting it slightly to the north of that line.*[9]

However, Cpl Dagg suggests that the report was lacking in information and details as to *how* Cst Gurzinski made his findings. Had more supporting information been included with the report, many of the subsequent questions not have arisen.

As a result of these identified weaknesses, Cpl Dagg made the following recommendations:

1. Consideration should be given to using a dedicated team approach to investigating serious motor vehicle collisions much the same way as any other unnatural death would be investigated.

2. Regardless of the type of approach to the investigation, much more emphasis needs to be placed on the taking of detailed and informative statements, whether that be in the first instance or in follow-up interviews.

3. File management for cases such as this with a large volume of information needs to be addressed. Cpl Dagg suggests the Oak Bay Police Department adopt the "Tips" system that is used by the RCMP, whereby the file coordinator is in much better control of the file and follow-up tasks can be diary dated and monitored more closely.

4. Collision Reconstruction or Technical Analysis reports should include more information than was provided in the report with respect to this file.

[8] File Review by Cpl Dagg, p. 12
[9] File Review by Cpl Dagg, p. 11

> Measurements, mechanical information of the vehicles and the analyst's calculations should be contained within the report.

In my opinion, Cpl Dagg's review very concisely and accurately pinpointed the areas of the investigation in which the Oak Bay Police were lacking and made appropriate recommendations as to how to improve their performance in the future. The Oak Bay Police Board accepted the findings of Cpl Dagg, and has revised its Traffic Collisions/Motor Vehicle Incidents policy to reflect the first three recommendations.

Cpl Dagg's review identified deficiencies in the investigation, but concluded these flaws did not affect the Collision Reconstruction Report. Cpl Dagg's recommendations to improve future investigations by the Oak Bay Police into fatal or serious injury motor vehicle accidents have been accepted and their policy has been amended. As mentioned earlier in this report, with respect to the Service & Policy component of this complaint, I am satisfied that the Board's decision and action are appropriate and adequate.

Although Cpl Dagg's report was not intended to respond to the later filed *Police Act* complaint, I believe Cpl Dagg's report addresses some of the public trust deficiencies in the investigation in a more accurate and focused style than Sgt RM's report, and accordingly, is very helpful.

Analysis

Sgt RM's Final Investigation Report attempted to address each and every question the Complainants have raised and I commend him for his efforts. I do not propose to review each response individually in this report, as I do not believe that is either necessary or productive.

Request for a Public Hearing

On February 20, 2006, this office received a voluminous undated document with attachments from the Complainants outlining their ongoing concerns with respect to the quality of the investigation conducted by Sgt DM and Cst IC into the motor vehicle death of HM. I took the document to be an effort to persuade me to arrange a Public Hearing on my own initiative, however if I was not so persuaded, then the Complainants were formally requesting that I do so. In either event, the same statutory test governs the exercise of my discretion: as police complaint commissioner, I may arrange a public hearing if I determine "that there are grounds to believe that a public hearing is necessary in the public interest".

Pursuant to s 60(5) of the *Police Act,* I am required to consider a number of factors in deciding whether a public hearing is necessary in the public interest:

Seriousness of the Complaint & Harm Alleged to have been suffered by the complainant (Section 60(5)(a), (b))

HM died as a result of injuries she sustained after being struck by a vehicle on September 28, 2003. The subsequent police investigation into a motor vehicle accident, particularly when there is a fatality involved, ought to be conducted in as thorough and professional manner as reasonably possible. The complaint alleges that the investigation conducted by Sgt DM and Cst IC fell short of the public's expected standard and, as a result, no criminal charges were laid against the driver of the vehicle. While the alleged police misconduct obviously did not cause the death, I accept that the Complainants feel harmed by what they subjectively regard as a lack of proper investigation into their daughter's death. I therefore accept that the harm they allege to have suffered is serious, pursuant to s. 60(5)(b).

I also accept that this makes the complaint a serious one from their perspective. However, as I have concluded elsewhere, there is necessarily an objective component to my determination about the "seriousness of a complaint". This includes an assessment of its persuasiveness in all the circumstances.

As stated earlier, the Report to Crown Counsel submitted by Sgt DM was reviewed by three separate Crown Counsel. The unanimous decision was that criminal charges are not appropriate. Although it is alleged that the quality of the investigation resulted in charges not being laid, I have not been persuaded that Crown's decision was tainted by any investigative deficiencies. The Crown's decision was based on the *totality* of the evidence.

Whether an arguable case can be made that there was a flaw in the investigation? (s. 60(5)(d)(i)). Is there a reasonable prospect that a Public Hearing would assist in Ascertaining the Truth? (s. 60(5)(c))

In my view, an arguable case can be made that there was a flaw in the investigation. I would preface my comments in this regard by observing that there were obstacles associated to this file that may have prohibited *any* investigator from completing a flawless investigation:

1) The Complainants' requests for answers to questions, many of which were simply impossible to answer, based on inaccurate recollections or hearsay, or which had been answered many times before, clouded the focus of the investigation. To Sgt RM's credit, he attempted to answer each and every question the Complainants put forward, even though some of those questions were beyond the scope of his investigation.

2) Sgt RM appeared to rely upon statements made by the Complainants as fact, without proper supporting evidence or investigation.

3) The Oak Bay Police investigation file was poorly documented. The lack of police officers' notes or Continuation Reports on the file make it difficult, if

not impossible, to confirm dates and times certain events happened. I can understand why Sgt RM accepted some of the Complainants' assertions as fact in the absence of such evidence, but as a result, there are potential inaccuracies contained in his report.

These points having been made, the concerns I have identified about Sgt RM's Final Investigation Report are as follows:

- Perhaps the most significant issue is the confusion surrounding the date Sgt DM accompanied Mr. D and Mr. S back to the scene to clarify their statements. The Complainants are adamant that they observed Sgt DM on October 3, 2003 at the scene of the accident with the witnesses. Sgt DM is equally adamant that this event occurred only after he received the translated statement of Mr. D, which was October 20, 2003. This time difference is significant because of the information that Sgt DM would have had on the 20th but not on the 3rd. As Sgt DM explained, the purpose of his re-attending the scene with the two drivers was to follow-up on the statements provided by Mr. D and Mr. S and to help clarify the event in his own mind. He was aware that there were other eye-witnesses who placed Mr. S's cab at the scene when they first arrived. Therefore he knew Mr. S's initial statement was not completely forthcoming and he was able to establish that Mr. S did, in fact, know that the other cab had struck his last passenger, but he had driven away because he was afraid. Sgt DM included this information in the Report to Crown Counsel, but neglected to document or record any of this important information anywhere on the file.

  Throughout his report, Sgt RM accepted as fact the date supplied by the Complainants and as a result drew certain conclusions and criticisms of Sgt DM's investigative abilities which may not be warranted.

- Sgt RM repeatedly referred to "five independent witnesses" who place Mr. S parked at the scene "well after" the accident occurred. Sgt RM identifies the five witnesses. I have carefully reviewed each statement. It is clear that two of the witnesses, KS and JW, *did not* report seeing a second cab at the scene. In fact, at the end of KS's written statement, the officer specifically asked the following questions:

  Q: *Upon arriving at the scene, how many taxi cabs do you recall seeing?*
  A: *One. The one I described.* [D's cab]

  Q: *Did you observe any other person of East Indian descent at the scene other than the one you have already mentioned?*
  A: *No.*[10]

[10] Statement of KS, undated; Tab L of Investigation Report attachments

KS was driving westbound on Oak Bay Avenue when she saw the accident scene, before the police arrived. She left approximately five minutes after the ambulance had departed.

There were 11 civilian eye-witnesses at the scene. Of those only three reported seeing a second cab, but none reported seeing a second male of East Indian descent.

This error is significant because Sgt RM based his opinion of the credibility of Mr. S on this incorrect evidence. Throughout the report criticized Sgt DM for his belief in Mr. S's version of events.

- Sgt RM concluded in his report that Sgt DM failed to forward to the Crown a copy of Cst Gurzinski's "Addendum" to his Collision Analyst & Reconstruction Report. In our review of the file, we located a page entitled, "Attachments" that lists 10 tabs. Tab 7 is described as:

  > *Report from Baker Materials Engineering Ltd dated 11 February 2004 [Collision Report paid for by the* Complainants*] and, letter from Jones Emery Hargreaves and Swan dated 9 February 2004. Also, a response to the correspondence of this report and letter by Cst Gurzinski.*

  This is to be considered in conjunction with an entry on a Continuation Report by Sgt DM on May 31, 2004 that reads:

  > *The RCC has been extended to include more information. The package has been bound in black binders. Two have gone to Crown, Attn: Steve Salmond, Chief Crown Counsel. One has been placed on the file folder.*

  It would have been helpful if Sgt DM had itemized of what the "more information" consisted. I conclude from these entries that it is likely that Cst Gurzinski's supplemental report was in fact forwarded to Crown Counsel. The Crown would not have a record of exactly what information they reviewed any longer, since no charges were laid. The file would have in the normal course of business, been returned to the police.

  The fact that it is so difficult to determine whether this material had been forwarded to Crown is indicative of the poor documentation and note taking on the master file. As the assigned file co-ordinator and exhibit officer, this was the responsibility of Sgt IC and he has accepted the findings of the Discipline Authority in this regard.

Sgt RM throughout his report faults Sgt DM for not first obtaining a warned statement from Mr D. However, it must be remembered that Sgt DM responded to the call of a "pedestrian struck injury MVI". When he arrived at the scene, the driver

was standing nearby with his cell phone in hand. He had, in fact, called his dispatcher to call 911. There were approximately 11 witnesses on scene in addition to paramedics and fire department personnel. No one had witnessed the accident, apart from the driver, who was cooperative with police and showed no signs of impairment. There was nothing said by either the driver or the 11 witnesses that suggested this was anything other than an injury motor vehicle accident. It was not a hit and run, the driver was not impaired and there were no apparent signs that the driver had been driving recklessly. With the information available to Sgt DM at the time, it may not have been appropriate or warranted to take a warned statement from Mr. D since there was initially no evidence that an offence had been committed. During the course of the investigation and once the traffic analyst had the opportunity to form opinions, if the evidence suggested Mr. D was perhaps criminally at fault, a properly warned statement could have been taken at anytime, albeit at a later date.

Sgt Symes made an entry on the police file on the day of the accident questioning whether a warned written statement should be obtained from Mr. D. Unfortunately, there is no follow-up to this entry.

Having discussed what I regard as arguable flaws in the investigation, it is my view that a public hearing would not provide additional evidence to assist either in a determination as to whether charges should be laid against the driver of the taxi cab, nor in relation to the issue as to whether the investigating police officers committed the disciplinary default of Neglect of Duty. Indeed, as I have noted, several of those flaws reflect conclusions that were likely too harsh in relation to some of the allegations against the respondent officers. Further, those flaws did not in any event factor into the Discipline Authority's ultimate decision.

Is there an arguable case that the discipline authority's interpretation of the Code of Professional Conduct Regulation, or his proposed discipline, was incorrect, inappropriate or inadequate? (s. 60(5)(d)(ii), (iii))?

Despite the above-noted questionable findings in Sgt RM's Final Investigation Report, it is my opinion in all the circumstances that a realistic case cannot be made that Chief Andersen's ultimate decision was flawed. He determined that Sgt DM and Sgt IC committed the default of Neglect of Duty with regards to their documentation and notes relating to the handling of exhibits. Sgt RM's report with respect to these allegations is not disputed by Sgt DM or Sgt IC and, based on my review, Sgt RM's findings in this regard appear to be based on sound evidence. Chief Andersen did not accept any of the other findings or recommendations by Sgt RM. It appears that Chief Andersen recognized that many of Sgt RM's opinions were not based on reliable evidence.

It may be argued that Chief Andersen could have expanded his decision to include a Neglect default with respect to Sgt DM's failure to properly document or record his follow-up conversations with Mr. D and Mr. S. Regardless of whether Sgt RM was confused on the dates that these conversations occurred, the fact remains that there is

inadequate reporting on the file regarding the follow-up conversations with these important witnesses.

With respect to proposed discipline, Sgt RM did not make any recommendations, leaving that decision to the Discipline Authority. Chief Andersen determined that a Verbal Reprimand was the appropriate discipline to be imposed after considering the provisions set out in the *Code of Professional Conduct*, and weighing the following the mitigating factors:

- Seriousness of the breach;
- Sgt DM and Cst IC's prior record of police service;
- The acceptance of responsibility of the breach and the willingness to take steps to prevent a recurrence of a similar breach in the future; and
- The range of disciplinary or corrective measures imposed in similar circumstances.

With respect to Sgt DM, Chief Andersen also reviewed submissions provided by Sgt DM, rebutting some of the more critical observations of Sgt RM.

Upon being advised that a Verbal Reprimand was the intended discipline, the Complainants wrote to our office on December 26, 2005, stating:

> *To us, this is simply another "slap in the face", and a total insult, and is completely inadequate, as we were expecting something far more severe.*

I have looked at the ranges of discipline imposed for similar breaches in other cases and have determined that the penalty imposed is within the accepted range. Similar cases indicate a range from no corrective/disciplinary measures being warranted to a written reprimand. It must be remembered that a verbal reprimand is recorded in writing and forms part of an officer's service record.

The *Code of Professional Conduct* specifies that:

> *If the discipline authority considers that one or more disciplinary or corrective measures are necessary, an approach that seeks to correct and educate the police officer concerned takes precedence over one that seeks to blame and punish, unless the approach that should take precedence is unworkable or would bring the administration of police discipline into disrepute.*

In my view the Service or Policy component of this complaint must be considered when considering whether this discipline addresses the public interest. Constructive steps have been implemented within the department's policy to ensure that future investigations into fatalities such as this are given the proper resources required and coordination with the team of Traffic Analysts are in place. In my view, this more effectively addresses the public's interest and confidence in the ability of the police to conduct thorough and professional investigations than any discipline against two officers might accomplish.

Undoubtedly, the actions of the officers fell short of the standard expected. However, given the circumstances, I agree with Chief Andersen's determination that a Verbal Reprimand was the appropriate discipline, and I do not believe it is realistic to conclude that a public hearing adjudicator would conclude otherwise. Chief Andersen could possibly have instructed Sgt IC to attend additional training courses regarding case management of major investigations as part of the disciplinary process, however that issue can be addressed through training programs to be scheduled by Oak Bay Police management.

Whether a hearing is necessary to preserve or restore public confidence in the complaint process or in the police? (s. 60(5)(e))

In my view, a public hearing is not necessary to preserve or restore public confidence in the complaint process or in the police. In light of the numerous reviews undertaken in this matter including the review by this office, the imposition of discipline, and the service and policy steps taken by the Oak Bay Police Department, I am not satisfied that a public hearing is necessary to preserve or restore public confidence in the police.

Public Hearing Decision – Conclusions

This case does not involve a death caused by a police officer. The *Police Act* process cannot be used to conduct an inquiry into whether the taxi driver committed an offence. Nor is this an inquiry to second-guess charging decisions made by Crown Counsel. The only relevant question under the *Police Act* is whether the respondent officers committed disciplinary defaults in *investigating* this tragic incident. I accept that this is a serious matter, and is especially so to the complainants.

But the decision whether to call a public hearing is not to be based on this question alone, or even a "tallying" of the factors in s. 60(5). The factors set out in s. 60(5) are not exhaustive. They are there to help guide the overall decision regarding there are grounds (which I take as meaning solid grounds) to believe that a public hearing is necessary in the public interest.

In answering this question, it is important in this case not to confuse the investigation into the accident with the *Police Act* investigation.

As to the former, I am satisfied that the review by external agencies, and especially the report of the Level 4 Collision Reconstructionist RCMP Cpl Dagg, confirm that even though the initial investigation was conducted in a manner that gave rise to discipline defaults, these defaults did not affect the ultimate outcome of the original investigation.

The investigative errors which gave rise to discipline defaults have been identified, defaults admitted, and appropriate sanctions imposed. A public hearing would not provide additional evidence to assist in a determination as to whether the investigating

officers committed discipline defaults. Nor am I satisfied that such a hearing is necessary to preserve or restore public confidence in the complaint process or the police. I have already indicated that, based on the defaults properly substantiated, the discipline imposed falls within a reasonable range of possible discipline and corrective measures. I am reluctant to call a public hearing to "tinker" with decisions that are within a reasonable and acceptable range of propriety.

In these circumstances, the existence of flaws in the subsequent *Police Act* "investigation of the investigation" cannot override the factors weighing against a public hearing. As noted, the flaws in the *Police Act* investigation led the investigator to be too harsh, in certain respects, on the respondent officers in the circumstances. As these flaws did not in any event impact on the discipline authority, this factor does not warrant a public hearing.

I have noted that the Service and Policy component of the complaint has also been appropriately addressed by the Oak Bay Police Board which revised the Traffic Collisions/Motor Vehicle Incidents policy to reflect Cpl Dagg's recommendations. Those recommendations, in part, include 1) use of a dedicated team approach to investigating serious motor vehicle collisions; 2) taking detailed and informative statements either in the first instance or by way of follow-up; 3) implementation of a "tip system" for file management.

In the end, while my profound sympathy continues to go out to the parents of HM, I have concluded, based on careful and detailed consideration of this file in light of my mandate, that it would not be in the public interest to arrange for a Public Hearing in this matter. Accordingly I hereby confirm the decision of the Discipline Authority.

Dated this 11th Day of April, 2006

_____

Dirk Ryneveld QC
BC Police Complaint Commissioner