# VANCOUVER POLICE BOARD

"PROVIDING INDEPENDENT CIVILIAN OVERSIGHT, GOVERNANCE, AND STRATEGIC LEADERSHIP TO THE VANCOUVER POLICE DEPARTMENT, REFLECTING THE NEEDS, VALUES AND DIVERSITY OF VANCOUVER'S COMMUNITIES."

## MEMO

To: Service or Policy Complaint Review Committee

From: Board Office

Date: July 11, 2023

Subject: OPCC 2021-19359 and 2021-20873

**PURPOSE**

FOR DECISION of the Committee's response to OPCC recommendations.

**RECOMMENDED RESOLUTION**

BE IT RESOLVED that the Committee ask the Chief Constable to report back the Committee any policy, procedures and training in relation to sudden death investigation, including:

a. how members and supervisors are trained, prepared and supported to document and investigate these matters to an impartial, objective and thorough standard;
b. emphasizing the independent role of the police in sudden death investigations vis-à-vis the Coroner in determining the circumstances of death;
c. an assessment of how the requirements of *Provincial Policing Standard Section 6.1.1 (Promoting Unbiased Policing)* are being implemented to assist the development of relevant policy, procedures, or training; and
d. any recommendations to amend policy, procedures and training for the consideration of the Police Board.

**SUMMARY AND KEY POINTS**

On April 14, 2023, the OPCC sent correspondence to the Board Office regarding two VPD investigations that recently concluded. The underlying facts and history may be found in the OPCC's letter that is attached as an appendix to this memorandum.

Office of the
Police Complaint Commissioner

British Columbia, Canada

April 14, 2023

**VIA E-MAIL: jason.kuzminski@vancouverpoliceboard.ca**

His Worship Mayor Ken Sim
Chair, Vancouver Police Board
City Hall 3rd Floor 453 West 12th Avenue
Vancouver BC, V5Y 1V4

Dear Mayor Sim,

**Re: Recommendation to the Vancouver Police Board to Examine and Reconsider Policies and Procedures Pursuant to Section 177(4)(c) of the Police Act.**

I write regarding matters related to two investigations undertaken by the Vancouver Police Department (VPD) that have been ongoing since 2021 and have recently been concluded. Section 177(4)(c) states that the Commissioner may make recommendations to Police Boards "*that it examine and reconsider any policies or procedures that may have been a factor in conduct that is the subject of a complaint or an investigation*" under Part 11 of the *Police Act*. As this relates to sensitive matters, I have omitted names of individuals and ask that you treat the information provided herein with appropriate confidentiality. I further wish to inform the Board that the circumstances of this matter are disturbing and may be triggering and traumatic for some.

**OPCC File 2021-19359**

On March 9, 2021, the Office of the Police Complaint Commissioner (OPCC) received a registered complaint from a complainant alleging a deficient police investigation and mistreatment by a VPD member during the course of a sudden death investigation of her daughter at an Indigenous affordable housing complex. Both the complainant and the deceased daughter identified as Indigenous. The complaint was made admissible and remitted to the VPD Professional Standards Section for an investigation.

This matter proceeded to a discipline proceeding before a retired judge where the member was ultimately found not to have committed misconduct. The retired judge, however, did find that the member failed to adequately document details in relation to the appearance of the scene and obtain witness statements, which fell short of the standards set out in departmental policy and the Justice Institute of BC (JIBC) training manual.

Clayton Pecknold
Police Complaint Commissioner

5th Floor, 947 Fort Street
PO Box 9895 Stn Prov Govt
Victoria, British Columbia V8W 9T8
Tel: (250) 356-7458 Fax: (250) 356-6503

Toll Free 1 877-999-8707 ⌗ Website: www.opcc.bc.ca

Specifically, the retired judge remarked that the JIBC materials outline the respective roles of the Coroner and of police officers in investigations and provided that the investigative objective for officers, in part, is to obtain information about the identity of the deceased and the circumstances surrounding the death (where, when, and by what means).

The retired judge further remarked that, while the member explained that he believed his duties were discharged by the Coroner's indication that the death was accidental, the policy and manuals specifically state that such an assessment does not relieve attending officers of fulfilling their function of answering questions surrounding the death.

On further assessment of the evidence, the retired judge highlighted the evidence of a senior VPD officer in charge of overseeing sudden death investigations who commented that the increased number of sudden death overdose cases have made investigations of apparent overdoses "something of a routine matter" and have resulted in instances where investigations are not conducted in as fulsome a manner as envisioned by VPD policy and training provided by the JIBC.

In reflecting on the evidence of the senior VPD officer in the present case, the retired judge concluded that such evidence supports the view that officers are not trained sufficiently to the standards, or that the increased demand on resources caused by the opioid crisis has diminished the expectations of officers to ensure complete documentation with respect to sudden death investigations. Accordingly, the retired judge recommended that VPD members could benefit from a renewed emphasis during regular cycle training on the regulations and policies with respect to sudden death investigations, and that supervisors could be encouraged to take a more direct role in evaluating sudden death investigations, including providing guidance where appropriate.

**OPCC File 2021-20873**

On December 6, 2021, the OPCC received a registered complaint from a complainant alleging a deficient police investigation into the death of her daughter. The complaint was made admissible and remitted to the VPD Professional Standards Section for an investigation.

During the course of the investigation, it was determined that the death of the complainant's daughter occurred in a Single Room Occupancy in the Downtown Eastside (DTES). Additionally, one of the respondent members provided evidence that all of the 19 sudden death investigations they have conducted in the DTES have been the result of accidental overdose, or caused by medical distress, and that drug overdose deaths are a common occurrence in the DTES due to the illicit drug trade.

At the conclusion of the investigation, the Discipline Authority found that the members had not committed misconduct. The Discipline Authority found that the members discharged their duty to investigate the death, and concluded that members acted in accordance with VPD sudden death policy by obtaining statements upon attending the scene, reporting concerns to their supervisor regarding possible suspicious circumstances, and requesting that the Coroner

attend. Following the Coroner's assessment that the death was apparently an overdose and not suspicious, the investigation was concluded.

In assessing the evidence and the follow-up investigative steps identified by a supervisor in consultation with the Major Crime Section, which were terminated following the Coroner's assessment, the Discipline Authority noted that the Coroner's assessment meant the file would not be considered a homicide and an investigation into a possible homicide would cease to continue.

Upon concluding our review of this matter, our office found that VPD's policy 1.6.38 Sudden Deaths does make a distinction between the role of the Coroner versus the role of the police in investigating sudden deaths. Specifically, sections 29 and 30 of the policy states that:

> *"The **cause of death** can only be determined at the conclusion of the coroner's investigation…"; and*
> *"The **circumstances of death** may only be determined at the conclusion of the police investigation…"*

This delineation of roles, however, is not reflected prominently within the policy; rather, the distinction is contained within a procedural portion of the policy that pertains to Next-of-Kin Notifications.

**Matters Related to Policies and Procedures**

I am satisfied that the Vancouver Police Professional Standards Section conducted a thorough investigation into the matters related to misconduct. However, having reviewed the available evidence, I am of the view that policy and training aspects in relation to sudden death investigations may have been a factor in conduct that is the subject of investigation.

The foregoing examples highlight the deference that appears to be placed on the Coroner's assessment, notwithstanding the fact that it is the duty of police officers to investigate the circumstances of a death and exclude the likelihood of criminality. Additionally, these examples are illustrative of the apparent impact that the opioid crisis has had on police response to sudden deaths precipitated by the opioid crisis.

Given the disproportionate impact of the opioid crisis on marginalized communities, it may also be noted that these matters relate to the promotion of equitable and unbiased service delivery to socially and/or racially marginalized communities, which is expressed through the provincial policing standards.

**Recommendation**

Accordingly, pursuant to section 177(4)(c) of the Act, I recommend that the Board:

1. Review and amend, as may be required, any policy, procedures, and training in relation to sudden death investigations with an emphasis on:

a. Ensuring members and supervisors are adequately trained, prepared, and supported to document and investigate these matters to an impartial, objective, and thorough standard; and
b. Emphasizing the independent role of the police in sudden death investigations vis-a-vis the Coroner in determining the circumstances of the death.

2. Consider the requirements of *Provincial Policing Standard Section 6.1.1* (*Promoting Unbiased Policing*) to assist in this review and the development of relevant policies, procedures, or training.

Please be informed that, while the names of the involved parties will remain confidential, the recommendations and a synopsis of the circumstances, including any actions undertaken by the Board in response, will be published in our 2023/2024 Annual Report anticipated for release in the fall of 2024.

In you require any further information I invite you to contact Deputy Commissioner Andrea Spindler at (250) 953-3895 or by email at aspindler@opcc.bc.ca.

Sincerely,

Clayton Pecknold
Police Complaint Commissioner

cc: Chief Constable Adam Palmer, Vancouver Police Department
Glen Lewis, Associate Director of Police Services