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A Review of the Investigation into the Police-Involved Shooting at the Starlight Casino on November 8, 2012

By Doug Kiloh

A Report to the Chief Civilian Director of the Independent Investigations Office

Executive Summary

This report is intended to inform the Chief Civilian Director (CCD) of the Independent Investigations Office (IIO) of my findings and recommendations based on the material I have reviewed related to the IIO's investigation into the police-involved shooting at the Starlight Casino on November 8, 2012.

The purpose of this review is to:

- identify any and all deficiencies in this investigation;
- review initiatives undertaken by the IIO since this investigation aimed at improving the IIO's investigative processes; and
- provide recommendations on further initiatives I determine are necessary, including further training opportunities for the IIO.

For this review, I have relied on the disclosure packages to Crown and investigation material, a limited review of closed IIO cases, Criminal Justice Branch's media statements, and limited interviews of IIO staff. I also relied on my experience as a former police officer involved in Major Case Management (MCM), and as an Emergency Response Team (ERT) member, team leader and team commander. I must also emphasize that the findings below are my assessment of the material I reviewed.

In 2012-2013, the IIO lacked clear policies, processes, procedures and training for its investigators, all of which contributed to the various challenges. The overarching issue is that the investigation lacked focus, detail and a disciplined structure. It did not utilize principles of MCM or an appropriate management system and structure. I have outlined these deficiencies in greater detail in this report.

While there were a number of shortcomings with the investigation, including with respect to the report to Crown counsel, the Crown made a number of additional requests for information from the IIO, and ultimately carried out their independent charge assessment process which led to a charge being laid against a Delta Police officer (the subject officer). However, after further independent review, the Crown later entered a stay of proceedings.

It was evident from my examination of the investigative material and other information obtained during my review that the IIO has made significant improvements since this investigation. These include: a manual of investigations; greater involvement by the Chief of Investigations throughout the life of a file; some improved policies and procedures; structured training for investigative interviewing; MCM and Team Commander standards; and structured

induction for new investigators. In addition, a number of subject matter experts have been employed to train, coach and mentor investigators.

While progress has clearly been made, significant investment in training will need to continue to ensure high quality investigations is the standard.

The work of the IIO is a critical component of improving the public's confidence in the justice system. Both the police and the public have a vested interest in the success of this office. As such, I have outlined recommendations below, some components of which have already been implemented. These recommendations are identified and expanded on throughout this report.

IIO investigation and subsequent events

On November 8, 2012, the IIO was notified of, and initiated an investigation into the wounding and subsequent death of a male affected person (AP). The investigation is the subject of this review.

On July 13, 2013, a report was submitted to Crown counsel for consideration of charges if an offence *may* have been committed. This process is required by the *Police Act* when the Chief Civilian Director of the IIO considers that any offence may have been committed under any enactment. The threshold for referral to Crown is lower for the IIO than for other law enforcement agencies in the province.

On July 29, 2013, the Director of the Appeals and Special Prosecutions of the Criminal Justice Branch (CJB) requested further information to process the material for 'charge approval' assessment. Subsequent disclosure was provided to CJB through to October 9, 2014.

On October 9, 2014, CJB informed the IIO that their charge assessment process was complete, and on October 20, 2014 the subject officer was charged with one count of second degree murder for the death of the AP. On July 14, 2015, CJB entered a stay of proceedings against the subject officer.

On March 31, 2016 the Delta Police Association, submitted a letter of complaint regarding the IIO investigation.

The sections below represent what I believe to be deficiencies and missed opportunities in the investigation. I have also included developments that have since been made at the IIO to address these deficiencies for your review and discussion. I have included my recommendations for your consideration.

Interviews and statements

A critical component to any comprehensive investigative action is the collection of witness statements through well planned and executed interview strategies. I have reviewed a number of statements taken by the police as well as some taken by IIO investigators. Overall, the investigation collected a significant volume of information, which provided a reasonable understanding of the events and how they unfolded, which then could be tied to other evidence. Base requirements were generally met and the main witnesses and issues were identified in the material forwarded to Crown. At the onset of the investigation, it appears that the IIO focused on officers who witnessed critical moments. However, a full interview plan, including witness officers and civilians, was not documented, prioritized, or sequenced, and I cannot confirm that potential evidentiary points were clearly articulated to investigators**.** I believe some opportunities were missed which may have provided useful information or improved the overall investigative structure.

The investigation did not interview a number of witnesses, and relied on statements taken by the police. Utilizing statements taken by the police is not problematic where there are multiple witnesses or parallel investigations, but it could raise the question of independence of the investigation. All witnesses identified were still available for Crown counsel should that have been deemed necessary.

The following deficiencies can be identified:

- there was limited documented rationale in support of interviewing selection and decisions;
- there was limited documented rationale of the priority of interviews;
- there appeared to be ambiguity with respect to investigating details of the affected person and his relevant background;
- there was limited rationale surrounding the use of police-obtained statements;
- there was limited or no documented contact with persons who had statements taken by the police (even by phone to confirm independence, any additional comments, etc.);
- there was no specific policy surrounding the use or analysis of police-generated statements.

Some key or significant witness interviews and issues are identified below.

Affected Person

The affected person, by IIO definition, was the subject of the application of force by the police. On November 8, 2012, he sustained a gunshot wound from the police. He was taken to hospital and received medical treatment for the injury. On November 15, 2012, he was transferred from

ICU and his condition was termed as 'stable'. After the IIO learned the affected person would possibly be available for interview, a decision was made to delay his interview. The rationale for the decision was not fully articulated on the file. On November 18, 2012, the affected person died before IIO investigators interviewed him. This gives rise to a number of issues or deficiencies, including:

- rationale to delay the witness interview was not fully documented;
- a documented interview strategy was not identified;
- communication between the IIO and police was not well documented; and
- a potential loss of opportunity to secure direct information from the AP (Notwithstanding that his statements may not have influenced or changed the rationale of police as it relates to their actions on the day).

A relative of the Affected Person

A relative of the affected person was not interviewed by the IIO. Although it is somewhat speculative, the relative may have had knowledge of the affected person's activity leading up to the event. The relative may also, through contact in the hospital, have been able to provide post-event information relevant to the standoff. The relative was not, however, a direct witness of the event. Potential issues or deficiencies:

- consideration of interviewing the relative was not properly discussed or documented; and
- communication with the police was not well documented in the IIO file with regards to the relative.

Former partner of the Affected Person

The affected person's former partner, whom he held hostage, was not interviewed by the IIO, but was interviewed by the police for approximately three hours. A decision was made to utilize the statement the former partner provided to the police. While it may have been in the best interest of the IIO to independently interview the former partner, declining to conduct another interview is not necessarily unreasonable, taking into account the former partner's trauma; that the former partner was not proximate to the actual shooting of the affected person; and the former partner had been adequately interviewed at length by the police. Potential issues or deficiencies are:

- a formal analysis of the former partner's statement that confirmed the independence of the interview and the collection of IIO specific needs was not evident on the file;
- direct contact with the former partner to confirm statement or provide the former partner with an opportunity for independent interview was not evident on the file; and

- a standard policy around the use and analysis of statements taken by the police was not in place at the IIO;

Crisis Negotiator Liaison

The police utilized a crisis negotiator liaison (CNL). His duties included 'running' communications to and from the command centre and the negotiators. All tasks, actions and considerations involving negotiations and informing or obtaining decisions from the Commander went through CNL. He was not interviewed by the IIO. The concurrent police investigation contained a summary of a statement from the CNL.

The CNL or 'runner' is a potentially significant witness who should have been interviewed. His notes, recollection, and accuracy may have had the ability to independently confirm or refute comments, information, statements or orders provided by officers in the negotiation or command groups. Potential issues or deficiencies include:

- the investigation lacked rationale for not interviewing CNL;
- further relevant expansion of specific issues contained in a summary statement of the CNL may have assisted the investigation; and
- a complete strategy, rationale or decision document for selection of the officers for interview was not evident on the file.

In addition to the issues above, some other considerations surfaced in my review of the interviews and statements:

- independence (or perception of independence) of police interviews of witnesses;
- properly considered, articulated and documented designations;
- properly considered, articulated and documented rationale on selection of witnesses;
- articulated advanced interview planning should be retained on file;
- structured analysis and oversight of all interviews or potential interviews to be conducted in a timely manner;
- common scripted questions or points of interest;
- documented resource considerations including who should interview which witness;
- use of subject matter experts to assist development of relevant questions (e.g. ERT); and
- communication of outstanding issues at briefings or through tasking;

Although a number of activities are underway to improve investigative interviewing at the IIO, the long term commitment to training and operational support for interviewing needs to continue. Although interviewing is a specific discipline requiring specific training, it also needs

to be supported with training, policy and practice relating to the overall case management structure, such as:

- providing more MCM training for directors and investigators;
- providing leadership and mentorship training;
- developing Standing Operational Plans (SOP's), and business rules around use of police statements; briefings; investigative oversight; statement and risk analysis; interview planning;
- increasing the practice and structure of risk analysis and critical thinking on all files;
- providing advanced training in interviewing skills, for all investigators; and
- documenting all interview activities and interview rationale.

Evidence, Experts and Exhibits

The care, collection, handling and continuity of exhibits and forensic material are paramount in any investigation. From simple numbering or identification procedures, through to a methodical and well planned scene examination, exhibits should be well managed.

It is evident that the handling of exhibits was not well executed. A range of issues, from minor numbering issues that caused a lack of clarity or confusion, to the "continuity of major exhibits" and pre-seizure by the IIO, raised questions related to the investigative integrity of some physical evidence. That should not occur in any investigation, let alone one of this nature.

A number of factors could have contributed to this, including the fact that the IIO did not have a complete and robust exhibit management system or a fully involved investigative manual in place at the time of the investigation. The lack of organizational direction appeared to lead to confusion among investigators with respect to managing exhibits and forensic material.

The IIO's initial submission to Crown did not include a use-of-force report. In July 2013, Crown requested that the IIO seek a use of force opinion. After consultation with a number of use-of-force experts, the IIO delivered a report from a use-of-force expert before the charge assessment in October 2014. The use-of-force report was obtained from an independent expert, and it was prepared in accordance with terms of reference set by Crown Counsel.

It is important to note that the use of force report appeared to indicate that the actions of the subject officer were in accordance with his training and policy.

Identified deficiencies include:

- the collection, continuity and documentation of a few critical exhibits was not fully documented and completed;

- not all available video from the casino was seized or viewed by the IIO;
- full analysis of the seized video was not immediately conducted and documented;
- complete forensic testing and expectations were not requested and fully realized by all investigators;
- inclusion or exclusion of the rationale of the various exhibit strategies was limited;
- the IIO did not have fully articulated and dedicated oversight of exhibits;
- tasking and responsibility as it related to each exhibit was not clear in the documents or notes of investigators; and
- a lack of a consistently-used Standing Operating Procedure for use of use of force experts.

Had this investigation continued to trial, further forensic analysis and more complete rationale for the investigators actions would likely have been required.

Developments

The IIO implemented a process of handling exhibits. Developments in this regard include the following areas:

- exhibit reviews and rationale for seizure, release or retention have been undertaken on some major investigations; and
- an exhibit manual and exhibit SOP's are being developed and incorporated in training.

Recommendations

- continually develop and refine the exhibit processes including; exhibit manual, SOP's, and business rules surrounding the collection, handling, care, continuity, retention and disposal of exhibits;
- develop a structured policy for collection, corroboration and analysis of electronic evidence;
- review the IIO's exhibit facility and customize according to needs;
- provide a secure repository for digital and electronic evidence;
- engage forensic specialists in training investigators on exhibit techniques;
- utilize documentation, oversight, and review of exhibits during MCM – CT process;
- provide independent oversight and routine audits of exhibit practices and facilities; and
- develop an approved list of court-qualified use of force experts that can provide an independent, unbiased, expert opinion.

Report to Crown Counsel

The purpose of the Report to Crown Counsel (RTCC), including the narrative, is to provide a comprehensive and organized summary of the evidence gathered in the course of the investigation. The police and the IIO have a specific, well-articulated MOU with CJB that speaks to structure, content and legal requirements. Although the basic needs of the RTCC submitted by the police or the IIO are similar, two significant differences remain: (a) the difference in the threshold for referral to Crown, which is lower for the IIO than other law enforcement agencies; and (b) their respective mandates. Notwithstanding the difference in threshold and mandate, I would expect that whether the RTCC was generated by the IIO or the police, it must meet the same rigorous standard of articulation of the evidence. Therefore, based on the same evidentiary need, Crown should expect to be able to: understand the organization, structure and content of the document and attachments; have the ability to logically search the documents; be provided a broad and inclusive disclosure package with all the appropriate information and evidence; and be able to independently complete their charge assessment process. It is common for Crown and the investigative body to discuss the RTCC for clarity or ask for follow-up around a myriad of issues. In my experience, once Crown is satisfied that there is sufficient coherence, accuracy and detail, they will conduct a charge assessment.

In this investigation, an initial RTCC was submitted, followed by supplemental documents requested by Crown. The Crown ultimately determined, and advised the IIO, that they had sufficient information to undertake their independent charge assessment process, which initially led to a charge being laid. As noted earlier, that charge was later stayed by the Crown.

In my examination of the RTCC, some deficiencies, even if inadvertent, are evident. Specific areas of concern include:

- the RTCC did not strictly adhere to the MOU between CJB and the IIO;
- some inaccuracies were identified;
- summaries were not fully reflective of the evidence that was available (inculpatory or exculpatory);
- evidentiary gaps were not fully explained or identified;
- comprehensive ‘decision logs’ on significant issues were not consistently produced and on file;
- links from the narrative to the source of the evidence was not always evident;
- the document did not provide a fully analytical perspective of all of the evidence; and
- appropriate oversight and review was not fully documented and the individual responsibility was not confirmed.

Developments

Since the time of this investigation, there have been a few pertinent developments:

- all reports to Crown now require review by the Team Director, Chief of Investigations and IIO legal services prior to submission; and
- IIO legal services provides comment for Crown on information or evidence where there may be an offence.

Recommendations

- the Report to Crown should adhere to the specific guidelines in the MOU between Crown and the IIO unless specifically modified, addressed and documented;
- the RTCC narrative should provide a well-organized, objective, comprehensive, sourced, document that chronologically lays out the theory of the investigation supported by documented and linked facts;
- the RTCC should be internally reviewed for structure, content and accuracy;
- evidentiary gaps or issues should be identified, addressed and documented prior and during an internal legal review;
- only an approved RTCC (Team Directors, COI Director of Legal Services) should be forwarded to the CCD;
- the CCD should be the final documented authority to forward the RTCC to Crown; and
- all disclosure should be documented and confirmed in the exchange with Crown.

Training

At the outset of this investigation, the IIO was still in its infancy. IIO management, directors and investigators lacked a consistent comprehensive level of training to fully comprehend and execute their mandate. The lack of a unified training regime was exacerbated by the diversity of the individual training and background of each of the investigators and supervisors. For example, a supervisor from outside of Canada, supervising investigators from civilian, military, and policing bodies who may also have come from the outside, provided opportunity for inconsistency within the investigation, including awareness of the Canadian legal requirements, file management or a number of other potential issues. At the time of the investigation:

- there was no consistent direction in training for IIO investigators from IIO management;
- there was no ‘off the shelf’ standardized training tailored for ‘oversight’ investigators;
- some staff suggested that the learning culture at the IIO was ad-hoc, subdued or disjointed with limited support from management; and

- there appeared to be a lack of coordinated training in the areas of advanced interviewing, file coordination, disclosure, scene management and exhibit handling.

Developments

- training has been, and continues to be, provided for IIO investigators and team directors in Major Crime Investigation Techniques (MCIT), Team Commander and file coordination. Structured training is provided in investigative interviewing techniques utilizing the PEACE model;
- in 2016, the Treasury Board approved funds to develop a training program for all IIO current and new hires to meet a required standard of training for independent oversight investigators. A Canadian subject matter expert was employed by the IIO to assist in developing the competency framework, identifying training providers, subject matter experts, and meeting IIO-specific requirements for training investigators. A three tier competency framework has been developed for all investigators with the objective of developing a certification program for oversight investigators;
- further, a moderation process was implemented at various stages in the investigation (approximately three weeks into a fatal investigation and at regular three month intervals for all files). The purpose of moderation is to evaluate evidence, assess the quality, complexity and status of the investigation, provide feedback and determine any further lines of inquiry. The process is probative and will identify good practice, deficiencies or challenges to assist the Command Triangle in their development and further steps in the investigation;
- briefing and communication has increased and a standard for briefings is being developed;
- in 2017, the IIO employed contractors with significant experience in Major Case Management and investigative interviewing. These contractors have a recognised standing in policing in Canada and are now tasked with mentoring and coaching IIO team directors and senior investigators in leadership and Major Case Management principles. Particular training, including coaching and mentoring one-on-one, is provided and will be continued. The specialist contractor provides interview advice as investigators plan and prepare for complex interviews;
- since 2012, some investigators have undertaken the Major Crime Investigation Training (MCIT): two in 2017 and two more booked for November 2017; and
- the Chief of Investigations has directed Team Commander training will be provided to investigation team directors.

Recommendations

Continue development and implementation of a competency-based framework for training IIO

investigators that is aligned with Police Services direction and guidelines.

Specialized training should be developed for the various roles on the investigative teams to reflect the specific needs of each function. Training should be considered as a dynamic and evolving challenge, sought after by all employees and supported as practicable by management. Continuing areas of education should include:

- leadership and mentorship training, for team directors and mentors;
- file coordinator's course for investigators;
- ongoing and advanced training in interviewing skills, for all investigators;
- preparation of judicial authorizations;
- project management (decision making, risk management, critical thinking);
- MCM at the investigator and command triangle levels;
- introduction or an overview of MCM for staff, IIO legal services and management;
- scene management and exhibit handling;
- refine internal and external communication;
- overview of Canadian law, disclosure, statements, use of force, tunnel vision, etc.; and
- utilize police, First Nations, and affected groups in training, and awareness;

Case management practices

Overall, the investigation did not utilize MCM or an equivalent case management system to guide the collection, corroboration, collation and disclosure of the investigation. Properly executed case management is supported in the courts and provides guidance to ensure a comprehensive and thorough, unbiased investigation.

Major investigations like this one require organization, documentation and leadership. MCM, as it is legislated in some provinces and is coming to B.C., is a system which has been shaped and supported by the courts to ensure that police investigations are open, transparent, and responsive to the law. Not all investigations are required to adhere to every aspect of MCM, but the principles found within it can provide guidance. As an example, MCM provides specific rules and roles for the leadership group or Command Triangle (CT). The CT provides investigators with investigative guidance and oversight; standards in the speed, flow, direction and detail of the investigation; support 'team' cohesion; and ensures overall standards of the investigative activity.

Although the diversity of an investigative body can add strength to an investigation, they must also understand and recognize the direction, need and requirements of an investigation within the area they are working. At the inception of the IIO, investigators were brought in from multiple organizations and locations (inside and outside of Canada), and had varying levels of

experience or understanding of their requirements of an investigation of this nature. Therefore, a robust and developed case management structure would likely have aided investigators.

As I have demonstrated earlier in this report, the IIO investigation lacked clear documentation of the rationale on key issues. As a result, it is difficult to specifically confirm the application of critical thinking at key moments in the investigation. That lack of documented and applied processes rightly allows for criticism of the IIO's presentation of evidence to Crown. It does not, however, indicate an intentionally weighted argument to clearly support charges against the subject officer as has been suggested in the Delta Police Association complaint. Furthermore, I did not review any material that would indicate that IIO investigators willfully held back evidence.

At the time of this investigation:

- there was limited development in areas such as an investigative manual, Standard Operating Procedures, or business rules to guide the investigators in carrying out their responsibilities;
- lack of proper procedures allowed gaps in reporting of task reports and narratives outlining investigative goals, plans, or issues under consideration;
- the IIO lacked an adequate or adequately followed electronic file system to support the appropriate documentation, tracking and monitoring of all the investigative and decision activity;
- inconsistent levels of understanding of case management existed within the investigative body;
- there was inconsistent and inaccurate accounting of all tasks;
- the inconsistent or lack of a demonstrated review of investigative material by leadership of the investigation indicated a lack of structure and skill;
- meetings and discussions between the IIO and Crown are not well documented;
- coordinated oversight and understanding of the needs of the investigation are not evident at all levels;
- significant individual roles were replaced during the investigation without appropriate understanding, quality control, investigation, tasks, and actions taken. As such, there was no quality assurance of the level required with the structure and oversight used in documenting and managing the file;
- "what investigators knew, when they knew it, and what they did about it" is critical in providing a clear picture of the events, as well as detailing the investigative actions, timing, facts and findings as a primary activity of any investigative body. This was not consistently apparent in this investigation; and
- documented 'speed flow and direction' of the investigation was not consistent or clear.

Developments

- in 2016, a project commenced to identify the IIO business and operational needs for an effective Case Management system conforming to Canadian standards. It is anticipated a new system will be in place in the coming months;
- at the same time, the investigative file process was reviewed to reduce bureaucracy and increase investigative efficiency. Consultation with key stakeholders, including the police and Criminal Justice Branch has resulted in training, mentoring and coaching of IIO staff to implement an evidence-led file process with improved timelines; and
- further, a moderation process was implemented at various stages in the investigation (approximately three weeks into a fatal investigation and at regular three month intervals for all files). The purpose of moderation is to evaluate evidence; assess the quality, complexity and status of the investigation, and determine any further lines of inquiry. The process is probative and will identify good practice, deficiencies or challenges to assist the Command Triangle in determining further steps in the investigation.

Recommendations

- adopt Major Case Management principles as prescribed by the province for police agencies (with practical adaptations);
- utilize a MCM software system and provide the necessary policies, business rules and training to staff;
- increase the sophistication and detail in case management (introduce or update – Manuals, SOP's, business rules, electronic case management);
- formalize and conduct proper investigative briefings and discussions;
- develop and support a formal decision process;
- document investigative decisions and strategies;
- have an internally independent investigator/supervisor review the investigation (during and post investigation);
- develop a formal briefing and information exchange with police when parallel investigations are ongoing;
- formalize and review all police obtained statements and examine for IIO content and requirement; and
- increase investigative and supervisory training such as: Major Case Investigative Techniques; file coordination; interviewing; critical thinking and decision making.

Conclusion

As stated in the executive summary, the purpose of this review was to:

- identify any and all deficiencies in this investigation;
- review initiatives undertaken by the IIO since this investigation aimed at improving the IIO's investigative processes; and
- provide recommendations on further initiatives I determine are necessary, including further training opportunities for the IIO.

It is my assessment that the IIO lacked clear policies, processes, procedures and training for its investigators, which I believe contributed to the various challenges I have outlined above. With respect to the IIO's investigation into the police-involved shooting at the Starlight Casino, I believe it did not meet all the expectations of a well-developed investigative unit. This included the Report to Crown Counsel, which led to the Crown requesting supplemental information so that they could complete their independent charge approval process.

With respect to the initiatives developed at the IIO, it is evident improvements have been made in structured training, and internal systems. It is essential these developments do not lose momentum and be continued.

Along with other reviews of the IIO, I have identified a number of recommendations. I trust these recommendations will also provide you with guidance in development of the leadership and investigative process.

Doug Kiloh, Supt. (Retired)

October 18, 2017