FINAL INVESTIGATION REPORT

DA 2022-0045 / OPCC 2021-120873

RESPONDENT MEMBERS

Constable Jordan Thauli – VPD

Constable Brad Willson - VPD

INVESTIGATOR

Sergeant Doug Dodd - VPD

OPCC ANALYST

Ms. Anahita Mittal

DISCIPLINE AUTHORITY

Inspector Sarah Burnham - VPD

December 2, 2022

TABLE OF CONTENTS

Contents

EXECUTIVE SUMMARY 3

RESPONDENT POLICE MEMBER 4

WITNESS POLICE MEMBER 4

CIVILIAN WITNESS 4

PROCEDURAL REPORTS 5

DATES OF SIGNIFICANCE 5

THE INVESTIGATION 6

- Investigative Steps 6
- Registered Complaint 6
- Notification of Admissibility of Complaint 7
- VPD PSS Alternate Resolution Attempt 7
- Respondent Member Identification 8
- Interview of Ms. Todorovic 8
- General Occurrence Report Review 10
- Review of Computer Aided Dispatch (CAD) 21
- Review of Coroner's Report 23
- Review of Video Interview of [redacted] 24
- Witness Member Interviews 26
- Respondent Member Statements 30
- Review of Member Training Records 37
- Policy 38
- Case Law 44
- Further Investigative Steps Requested by OPCC 44

ANALYSIS 50

- Definition of the alleged misconduct 50
- Standard of Proof 50
- Standard to Assess Credibility and Reliability 51
- The Available Evidence 53
- Issues of Law and Essential Elements of the Alleged Neglect of Duty 53
- Duties and Authorities of a Police Officer 53
- Neglect of Duty - Defined 54
- Assessment 55
- Conclusion of Analysis 71

CONCLUSION 71

ATTACHMENTS 72

EXECUTIVE SUMMARY

1. On December 6, 2021, the Office of the Police Complaint Commissioner (OPCC) received a copy of Ms. Debby Todorovic's (Ms. Todorovic) registered complaint in relation to an investigation that members of the Vancouver Police Department (VPD) conducted on September 1, 2021.

2. On September 1, 2021, Ms. Todorovic's daughter: Ms. [redacted] (Ms. [redacted]) passed away in suite [redacted], Vancouver. Constable Jordan Thauli (Constable Thauli) and Constable Brad Willson (Constable Willson), with the assistance of other VPD police officer's, were assigned to investigate the death.

3. After conducting their investigation and liaising with the BC coroner service, Ms. [redacted] death was determined to be a result of an apparent accidental drug overdose and the file was closed. Due to confusion of Ms. [redacted] identify, Ms. Todorovic was not notified of her daughter's passing until September 10, 2021.

4. Ms. Todorovic lodged a registered complaint with the OPCC claiming that she wasn't provided details of her daughter's death, and that somebody must have lured her daughter into the suite, gave her the drugs that killed her and that person should be arrested for murder. Furthermore she claimed that when she spoke with Constable Thauli on the phone, he advised her the file was closed. Ms. Todorovic spoke with multiple VPD supervisors and was told the same thing. She requested that the file be re-opened and investigated further.

5. On January 21, 2022, the OPCC received "additional information" from Ms. Todorovic, which "includes that she has been advised that her daughter was found at an apartment on Powell Street and that there was no indication of foul play. Additionally, she reports that police have advised her to speak to the coroner multiple times and in return, the coroner has advised her to speak to the police."

6. On March 7, 2022, the OPCC determined that the complaint was admissible and that based on the information provided by Ms. Todorovic, the conduct alleged in relation to her allegations that police failed to adequately investigate the circumstances of her daughter's death would, if substantiated constitute misconduct, namely:

    6.1. Neglect of Duty pursuant to section 77(3)(m)(ii) of the *Police Act* by neglecting, without good or sufficient cause, to promptly and diligently do anything that it is one's duty as a member to do.

7. On March 8, 2022, Detective Constable Alvin Prasad ("Detective Prasad") from the Alternative Resolution Team ("ART"), was assigned the file.

8. On March 11, 2022, Detective Prasad had a phone conversation with Ms. Todorovic, whom advised that she did not want the complaint resolved via alternate means.

9. On April 14, 2022, Sergeant Doug Dodd ("Sergeant Dodd") was assigned to investigate the complaint.

10. On April 27, 2022, Sergeant Dodd initiated the investigation.

11. Sergeant Dodd reviewed the complaint, the police report, Ms. Todorovic's statement, the coroner's report, police witness statements and the respondent police officer's statements.

12. In addressing the issues regarding the above allegations, Sergeant Dodd reviewed the essential elements of the alleged misconduct, the *Police Act*, VPD Policy and relevant case law.

13. Sergeant Dodd submits that the evidence set out below is not clear, convincing and cogent to satisfy the balance of probabilities test with respect to the allegation of misconduct against Constable Thauli and Constable Willson set out by the OPCC. Sergeant Dodd therefore recommends that the allegations of misconduct of *Neglect of duty* be **unsubstantiated.**

RESPONDENT POLICE MEMBER

14. The following Respondent Members were identified:

    14.1. Constable Jordan Thauli - VPD

    14.2. Constable Brad Willson - VPD

WITNESS POLICE MEMBER

15. The following Witness Police Members were identified:

    15.1. Sergeant Aaron Roed – VPD

    15.2. Constable Clayton Cheng – VPD

    15.3. Constable Jeremy Lashar – VPD

    15.4. Constable Ali Shirazi – VPD

CIVILIAN WITNESS

16. Ms. Debby Todorovic – Complainant

17. No civilian witnesses were interviewed by Sergeant Dodd during this police act investigation, however three civilian witnesses were interviewed during the sudden death investigation. Their statements are detailed in the General Occurrence Report review.

PROCEDURAL REPORTS

18. The following is a chronology of the *Progress Reports* submitted for this investigation:

18.1. Progress Report # 1	June 9, 2022
18.2. Progress Report # 2	July 8, 2022
18.3. Progress Report # 3	August 8, 2022
18.4. Progress Report # 4	September 6, 2022
18.5. Progress Report # 5	October 5 , 2022

DATES OF SIGNIFICANCE

19. The following is a chronological list of dates for significant events related to this investigation:

19.1. Date of Incident	September 1, 2021
19.2. Date of Registered Complaint	December 6, 2021
19.3. Date of Complaint Admissibility	March 7, 2022
19.4. File assigned to Detective Prasad	March 8, 2022
19.5. File re-assigned to Sergeant Dodd	April 14, 2022
19.6. Investigation Initiated	April 27, 2022
19.7. Constable Willson identified as a Respondent	September 29, 2022
19.8. 30 Business Day Extension Granted	October 27, 2022
19.9. Final Investigation Report	December 9, 2022

THE INVESTIGATION

Investigative Steps

20. The following investigative measures were conducted, which included, but were not limited to:

20.1. A review of the Registered Complaint;

20.2. A review of the Notification of Admissibility of Complaint;

20.3. VPD PSS alternate resolution attempt;

20.4. Interview of Ms. Todorovic, the complainant;

20.5. Review of the Coroner's report on Ms. [redacted] death;

20.6. Review of the VPD General Occurrence report;

20.7. Review of the Computer Aided Dispatch;

20.8. Interview of six witness members;

20.9. Reviewed the video interview of a civilian witness conducted by Constable Thauli;

20.10. A review of the Respondent Member's training records;

20.11. Interview with two Respondent Officers;

20.12. A review of policy and case law.

Registered Complaint

21. On November 29, 2021, Ms. Todorovic filled out and signed an OPCC complaint form. On December 6, 2021, the OPCC received that form, Ms. Todorovic alleged the following (quoted from a hand written form):

21.1. "RCMP Trail, BC. Cpl. Steve McKeddie brough me news on Sept 10.2021 the death of my daughter from VPD happened Sept. 1, 2021 on Pender St. [redacted] my daughter name.

I do not have much information to go on which is part of my complaint, I was told Sept. 1, 2021 death and the circumstances of her death was overdose. Mother has the right to learn all the circumstances surrounding he child's death. Who Lured her in place gave her Drug that Killed her is

guilty of Homicide or manslaughter call it what you like, who left her there and did not call 911 on time.

I called numerous times to Vancouver Police dept. got wrong files and misspelled names then spoke with Jordan thauli – 3250 and he told me file was closed, I asked how this could be and his female partner in the background actually laughed at which I commented "this is not a laughing matter"

Then they gave me name Tyler Dodds – 2421 same story file closed I called Corey Bach – 2226 same story file closed, got another name that was in the team and I called him Brad Willson – 3194 same story file closed. After I called aaron Roed – 2047 same story file clo

I do not fee that this matter was properly and fully investigated. I want this file opened and I want the information from this file."

[See Attachment A_Complaint Form]

Notification of Admissibility of Complaint

22. On March 7, 2022, the OPCC admitted Ms. Todorovic's complaint and identified the potential alleged misconduct, defined as:

    22.1. *Neglect of Duty* pursuant to section 77(3)(m)(ii) of the *Police Act* by neglecting, without good or sufficient cause, to promptly and diligently do anything that it is one's duty as a member to do.

[See Attachment B_OPCC Documentation]

VPD PSS Alternate Resolution Attempt

23. On March 8, 2022, Detective Prasad of the VPD PSS Alternate Resolution team was assigned the file. Detective Prasad had one phone conversation with Ms. Todorovic who advised that she did not want to participate in an alternative resolution.

24. On April 14, 2022, Sergeant Dodd was assigned to investigate this complaint.

25. On April 27, 2022, Sergeant Dodd initiated the investigation.

Respondent Member Identification

26. On April 27, 2022, based off of the registered complaint, Sergeant Dodd identified Constable Thauli as the respondent police officer.

27. On September 29, 2022, after interviewing Constable Willson, Sergeant Dodd determined that Constable Willson was also a respondent officer and notified him of this.

Interview of Ms. Todorovic

28. On Monday May 16, 2022, Sergeant Doug Dodd conducted an interview of Ms. Todorovic. The interview was done over the phone, and audio recorded. Sergeant Dodd asked Ms. Todorovic to express her interactions and main concerns freely, and conducted a series of questions afterwards. The interview is summarized as follows:

29. Pure Version:

    29.1. The interview began at 9:02 AM.

    29.2. Ms. Todorovic began that the reason she launched the OPCC complaint was that she felt that he daughter's overdose death was not investigated fully. Ms. Todorovic wanted the police to locate and arrest for murder, the drug dealer that had sold her daughter the drugs that had caused the overdose.

    29.3. Eleven days after the overdose, the local police (RCMP) knocked on Ms. Todorovic's door with a Victim Service worker and notified Ms. Todorovic of her daughter's death. The RCMP officer asked Ms. Todorovic to contact the VPD.

    29.4. Ms. Todorovic contacted the main switchboard, and eventually contacted Tyler Dodds and Corey Bech, and Jordan Thauli.

    29.5. Ms. Todorovic stated that "I couldn't get them, talk to them, because either they were away, or couldn't answer the phone"

    29.6. After getting a hold of Constable Thauli, Ms. Todorovic stated that she felt he was upset and unhelpful. He got the wrong file number, and believed that it was a missing person file and not an overdose.

    29.7. While Speaking with Constable Thauli, Ms. Todorovic felt that he was in a vehicle based on the background noise, and felt that Constable Thauli wasn't paying attention. Constable Thauli informed her that the file was closed. Ms. Todorovic stated "how can be closed? It is not even investigated. This file should not be closed, until it is investigated fully and

the criminal brought to justice". At this point she heard a female laugh "Haha" in the background.

29.8. Ms. Todorovic then spoke with Sergeant Roed, who also informed her that the file was closed. She then contact Sergeant Bech, who stated the same thing. He suggested reaching out to the coroner.

29.9. At this point Sergeant Bech stated that there was no foul play involved in her daughter's death. She stated that that she wanted the drug dealer brought to justice, whether there was foul play or not.

29.10. Ms. Todorovic was upset that she wasn't provided details surrounding her daughter's overdose death. She felt the officers were not paying attention when talking to her, and that more could have been done to identify and arrest the drug dealer that sold the drugs. Ms. Todorovic feels the drug dealer, if located, should be charged with manslaughter.

29.11. Ms. Todorovic feels that her daughter was lured to the place she died, as she [her daughter] had been a victim her entire life. This is based on Ms. Todorovic's suspicion of events. And feels a prosecution will reveal this.

30. Sergeant Dodd then went on with clarifying a few points from Ms. Todorovic's statement:

30.1. Sergeant DODD clarified the timeline of how and when Ms. Todorovic was notified. The RCMP provided a general line phone number for her to contact the police. After multiple attempts contacting the VPD switchboard, Ms. Todorovic was advised the lead investigators were Sergeant Bech and Constable Dodds.

30.2. Ms. Todorovic stated that she spoke with Sergeant Bech, who had the incorrect name for Ms. Todorovic's daughter. Eventually the correct name and file number was identified, Sergeant Bech directed Todorovic to Constable Thauli.

30.3. Ms. Todorovic left a message on Constable Thauli's voicemail. Constable Thauli and Ms. Todorovic spoke on the phone approximately 3-4 days later.

30.4. Ms. Todorovic spoke to Sergeant Roed at one point, who reiterated that the file had been closed, and that there was no foul play involved.

30.5. Ms. Todorovic stated that it didn't matter to her if there was foul play or not. She wanted the person that had sold her daughter the drugs to be arrested. Ms. Todorovic stated that her main concern was that the police hadn't identified the drug dealer and arrested him, and her secondary concern was when the female officer laughed in the background during her conversation with Constable Thauli.

[See Attachment C_Complainant Material]

General Occurrence Report Review

31. On July 7, 2022, Sergeant Dodd read VPD General Occurrence report for 21-156836 and learned the following:

32. On September 1, 2021, the General Occurrence information was:

    32.1. Main Offence: Sudden Death – Completed
    32.2. Operational status: Closed
    32.3. Location: [redacted], VANCOUVER
    32.4. District: 02 Zone: VAK Atom: VA4773
    32.5. Approved on: Tuesday, 2021-Sep-14 by: VA2139 MATSON, REBECCA
    32.6. Reported on: Wednesday, 2021-Sep-01 22:24
    32.7. Occurred on: Wednesday, 2021-Sep-01 22:00
    32.8. Drugs/alcohol involved: YES
    32.9. Submitted by: VA3250 THAULI, JORDAN Org unit: BEAT ENFORCEMENT TM2
    32.10. Accompanied by: VA3194 WILLSON, BRAD

33. The offences committed for the call were:

    33.1. SUDDEN DEATH - COMPLETED
    33.2. DRUG OVERDOSE-ILLICIT – COMPLETED

34. The related events were:

    34.1. CP VA 2021 – 148822 (CAD call)
    34.2. [redacted]

35. The related persons were:

    [Sergeant Dodd has left their addresses out]

    [redacted]

    [redacted]

[redacted]

36. The "Synopsis" report was authored by Constable Jordan Thauli ("Constable Thauli") stated:

    36.1. On September 01, 2021 at 2224 hours, Vancouver Police operators received information from EHS that they had units on scene at [redacted], Vancouver BC for a sudden death overdose.
    36.2. At 2236 hours, PC's arrived on scene and observed the female, identified as [redacted], deceased in unit [redacted].
    36.3. PC's spoke with the tenant of unit [redacted], [redacted], who claimed he had just met [redacted] that evening. However, staff members [redacted] and [redacted] advised they believed they saw [redacted] with a female, possibly [redacted] on the evening of August 31 at approximately 1800 hours.
    36.4. Clear inconsistencies in information given. Therefore, audio/video interview conducted with [redacted], written statements collected from [redacted] and [redacted]
    36.5. No obvious signs of trauma observed and [redacted] advised him and [redacted] smoked crystal meth together.
    36.6. File to remain open pending BC Coroner determination.
    36.7. MCS, A/Sgt 3282 CHENG, Car 10 all advised.

37. The "Narrative" report was authored by Constable Thauli and is summarized as follows:

    37.1. Under the title "Background of Events" the 4 entities for the investigation are listed with a brief synopsis of how they related to the file.
    37.2. Under the title "Circumstances of Events" it stated that on September 1, 2021 at 2224 hours, EHS contacted the VPD to advise of an overdose death at [redacted]. They stated the deceased was a 35 year old woman and there was nothing of suspicion.

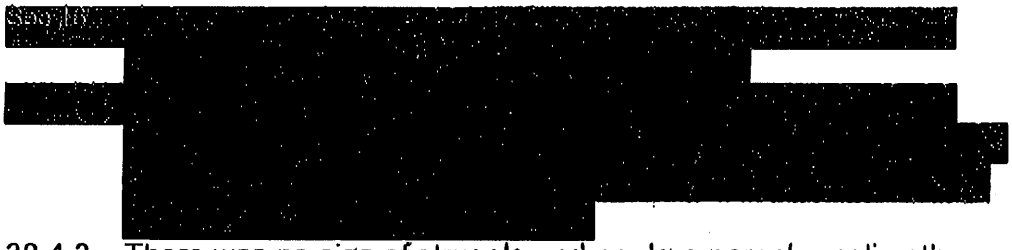
38. Under the title "Police Actions" it stated:

38.1. Constable Thauli and Constable Brad Willson ("Constable Willson") were on duty and working together when they were dispatched to this sudden death.

38.2. They arrived on scene at 2236 hours, where they met with EHS. EHS reported they had arrived at 2218 hours, the female was cold to the touch and rigor had begun to set in on her neck. They could not determine the cause of death, but did not observe anything suspicious.

38.3. Under the title "Deceased Identification" it stated that the deceased was originally identified as via a hospital bracelet as [redacted].

38.4. Under the title "Scene Upon Arrival" it stated:



38.4.3. There was no sign of struggle and no drug paraphernalia other than tinfoil near the deceased.

38.4.4. A paystub with [redacted] name was located in the deceased's purse, however no other ID was located.

38.5. Under the title "Initial Witness Statement by [redacted]" it stated [redacted] provided an initial verbal statement as follows:

38.5.1. He had met the deceased female at 2100 hours that evening at a nearby park.

38.5.2. At 2130 hours the deceased and [redacted] went to his home with a couple of coolers. The pair smoked some methamphetamine ("jib").

38.5.3. At 2200 hours [redacted] passed out for 20 minutes. When he woke up he tried to rouse the deceased, who would not wake.

38.5.4. He then attempted CPR and called EHS.

38.5.5. Under the title "[redacted] Initial Statement" it stated that [redacted] advised police that he believed he had seen [redacted] with a female the night before (August 31) at approximately 1800 hours.

38.6. Under the title "Police Actions Continued" it states that PC's noted the differences in [redacted] and [redacted] statement. The PCs determined that a thorough audio/video recorded message of [redacted] would be done, and the suite locked down while more investigation was completed.

38.7. Under the title "CCTV" it states to see PC Shirazi's police statement for details.

38.8. Under the title "[redacted] Written Statement" it states that PC Shirazi (Constable Ali Shirazi – "Constable Shirazi") took the statement from [redacted] as follows:

38.8.1. On September 1, 2021, at 2115 hours [redacted] went upstairs for an unrelated matter. He was approached by [redacted] who stated that he had a girl in his room from the previous night and she was passed out.

38.8.2. [redacted] told [redacted] she had to leave as no overnight guests were allowed.

38.8.3. [redacted] then saw [redacted] again at 2155-2200 hours, when [redacted] stated that he could not wake up the girl, and he asked [redacted] to help move her. [redacted] told him to call 911

38.8.4. [redacted] called 911 but lost connection during the first call, [redacted] then called 911 back and was able to connect to Ambulance.

38.8.5. At one point [redacted] asked if [redacted] had a wheelchair to move the female.

38.8.6. [redacted] stated that on the previous night (August 31, 2021), at just past 1800hrs [redacted] had come in with a black woman with short hair, 5'10 and slim to medium build. [redacted] stated they were going to sort bottles. [redacted] didn't see [redacted] with this female again.

38.9. Under the title "[redacted] Written Statement" it stated that Constable Shirazi took the statement as follows:

38.9.1. At 2225 hours [redacted] was called by [redacted], who informed him of the sudden death.

38.9.2. [redacted] went to the suite and met [redacted] who was standing with paramedics.

38.9.3. [redacted] apologized and told [redacted] that he had met the deceased an hour before in a park, and invited her over for a drink.

38.9.4. [redacted] told [redacted] that he had left the suite to get something, and when he came back the deceased wasn't breathing.

38.9.5. [redacted] stated "I don't know what she took or did while I was out. [redacted], I wouldn't do anything to harm you."

38.9.6. [redacted] remembered that at 0825 hours a tall, husky, older aboriginal male came to the building. He told [redacted] that he was there to see [redacted], and the male signed in as [redacted].

38.10. Under the title "[redacted] Audio/Video/Dar Witness Statement" it stated:

38.10.1. [redacted] consented to an audio/video recorded interview at a VPD police station.
38.10.2. PC Thauli conducted the interview.
38.10.3. [redacted] stated that he met the deceased female at Victory Square Park at approximately 2145 hours. It was cold outside and the sun was going down
38.10.4. This was the first time he had met her, he did not remember her name, they developed a friendship quickly, they both decided to go back to his place to watch a movie and cuddle.
38.10.5. They entered [redacted] at around 2201 hours and arrived at his room at approximately 2205 Hours, where they cuddled on his bed for 10 minutes.
38.10.6. In that time, they both took approximately 2 puffs of jib (crystal meth) each, she did not seem to have any negative response to the jib
38.10.7. [redacted] decided to get some coolers, so he left the room, she stayed in the room he left to go to the beer and wine store in the 500 Blk Abbott St and got a six pack of pineapple coolers.
38.10.8. [redacted] arrived back at his room at approximately 2225 hours she seemed to be asleep on the bed. She was on her back laying on the bed, feet hanging off
38.10.9. [redacted] tried to rouse her, but she was not waking up, he tried to rouse her by shaking her and lifting her up, but she was not responding. he also noticed her stomach was not moving and her eyes were open
38.10.10. After 10 minutes of no response he became worried, he asked for help to rouse her from "[redacted]", who lives one unit to the left (if facing [redacted]). [redacted] did not help
38.10.11. At approximately 2240 hours, he went to talk to [redacted]. [redacted] and him both went up to the third floor
38.10.12. [redacted] tried using the staff phone to call ambulance, but was not getting through so he gave the phone to [redacted] to try
38.10.13. EHS arrived on scene approximately 15 minutes after they had called.

39. Under the title "Disposition" it states that at the time of writing the suite was being held until the Coroner could arrive. If they deemed the death to be suspicious, MCS would have been called. [redacted] was advised not to return home for 24 hours. It further states that MCS, A/Sergeant Cheng and Car 10 had been advised.

40. The "Civilian Statement -1" page for [redacted] is a repeat of what was stated in the Narrative. This portion states a written statement was attached to the file.

40.1. The "Civilian Statement -2" page for [redacted] is a repeat of what was captured in the Narrative. This portion states a written statement was scanned into the file.

41. The "Police Statement -1" page for Constable Shirazi stated:

41.1. On September 1, 2021, at approximately 2342 hours, Constable Shirazi attended to assist with the sudden death investigation.
41.2. Constable Shirazi interviewed [redacted] and [redacted], and obtained the SRO's sign in sheet for the day from [redacted].
41.3. Constable Shirazi provided a business card to [redacted] and asked [redacted] to email if anything suspicious was seen on the video.
41.4. Constable Shirazi then conducted door knocks on neighbouring suites which resulted in unanswered doors, or nothing suspicious observed.

42. The "Police Statement -2" page for Constable Willson stated:

42.1. Constable Willson was on duty and partnered with Constable Thauli on September 1, 2021, when they responded to this sudden death.
42.2. Constable Willson first met with [redacted], and then attended the 3rd floor where he observed [redacted] in the hallway with his head in his hands, with two paramedics.
42.3. Constable Willson spoke with the paramedics who stated that they observed the female to obviously be deceased, the body had the start of rigor mortis in her jaw, with lividity in in her lower back. The paramedics believed the female to have been deceased longer than what [redacted] had originally stated.
42.4. Constable Willson spoke with [redacted] who advised he had just met the female an hour previous.
42.5. Constable Willson entered the room and observed a female laying partially on the bed, with her lower half on the ground. The female appeared to be Caucasian or mixed race, in her 30'2, medium build with short dark hair. The female had a bandage on her arm.
42.6. Constable Willson did not observe any drug paraphernalia in the immediate area, or signs of distress.
42.7. Constable Willson then spoke with [redacted] who stated that at 2115hrs, [redacted] had told staff that he had a girl in his room from overnight, and that she was passed out. [redacted] told [redacted] to get her out. At 2200 hours, [redacted] went downstairs and advised he couldn't wake the female, and asked for a wheelchair.
42.8. Constable Willson believed the death to be suspicious, and called A/Sergeant Cheng to advise him of the circumstances.
42.9. Constable Willson notified the BC coroner services.
42.10. Constable Willson monitored [redacted] voluntary interview.

43. The "Police Statement -3" page authored by Acting Sergeant Clayton Cheng ("A/Sergeant Cheng") stated:

    43.1. On September 1, 2021, A/Sergeant Cheng was on duty, as the supervisor for BET 2.
    43.2. At 2248 hours, Constable Willson and Constable Thauli notified A/Sergeant Cheng that the sudden death they were investigating had circumstances that were suspicious.
    43.3. At 2259 hours A/Sergeant Cheng arrived at the scene of the sudden death. Constable Willson advised that no coroners were available at the time.
    43.4. A/Sergeant Cheng notified car 10; Inspector Randy Bell ("Insp. Bell"), and Homicide Unit Detective Constable Lawrence Lui ("Detective Lui") of the circumstances of the sudden death and lack of coroner availability.
    43.5. A/Sgt, Cheng devised a plan to hold the suite until the coroner could attend and confirm or not if the death were suspicious. A/Sergeant Cheng then delegated the following tasks to members:
    43.6. Constable Willson and Constable Thauli were to conduct an audio/video recorded interview with the owner of the suite
    43.7. Constable Shirazi was to obtain statements from the SRO staff and any possible video footage
    43.8. Constable Sexsmith and Constable Laviolette were to hold the suite until relieved by other police members or until the Coroner got on scene.
    43.9. A/Sergeant Cheng liaised with the dayshift BET Sergeant to conduct various tasks during the daytime. They were:
        43.9.1. Obtain statements from the attending paramedics.
        43.9.2. Conduct door to door knocks on the third floor.
        43.9.3. Obtain video from the SRO staff.

44. The "Police Statement -4" page authored by Constable Jeremy Lashar ("Constable Lashar") stated:

    44.1. On September 2, 2021, at 0230 hours, they were on duty with Constable Graham Haddon ("Constable Haddon"), and attended suite [redacted] to relieve Constable Sexsmith and Constable Laviolette of their guard duty of the suite.
    44.2. At 0207 hours, Coroner [redacted] ([redacted]") attended, deemed the death as not suspicious, and that the deceased likely died of an overdose the evening before.
    44.3. At 0430hrs, Constable Lashar informed Acting Sergeant Stu Hurst ("A/Sergeant Hurst") of the Coroner's findings. A/Sergeant Hurst advised Constable Lashar to contact body removal.
    44.4. Constable Lashar secured a purse that belonged to the deceased, as well as rings and a necklace that was on the body. These items were eventually given to a CSP to be tagged for safekeeping at the VPD property office.

44.5. At 0722 hours, "Global Body Removal" attended the scene and transported the body to Glen Haven Funeral Home. Constable Lashar then locked the suite and left the key with staff.

45. The "Police Statement -5" authored by Constable Joelle Sexsmith ("Constable Sexsmith") stated:

45.1. On September 1, 2021, Constable Sexsmith was on duty in company of Constable Laviolette.
45.2. At 23:50 Hours, Constable Sexsmith and Constable Laviolette took over containment of suite [redacted] from Constable Thauli.
45.3. On September 2, 2021, at 0250 hours, Constable Lashar and Constable Haddon took over containment.

46. The "Police Statement - 6" page authored by Acting Sergeant Tare Munro ("A/Sergeant Munro") stated that the Coroner had not found anything suspicious about the death, and no drugs or drug paraphernalia had been located, OCS would not be conducting an investigation.

47. The "Police Statement - 7" page authored by Community Safety Special Constable Robert Bauerfind (S/Constable Baurefend') captures how he tagged the purse and other items at the VPD property office.

48. The "Police Statement -8" page authored by Constable Thauli stated:

49. That as per the BC coroner's finding that the death was likely an overdose and not suspicious, the file would be concluded as a sudden death.

50. The deceased did not hait to identify and notify next of Kin. Further, that the homicide unit would be updated.

51. The "Police Statement -9" page authored by Constable Brendon Frick ("Constable Frick") stated:

51.1. On September 15, 2021, Constable Frick received a message from E-Comm to contact Debra Todorovic as she had contacted the non-emergency line and asked to speak to Constable Frick by Name.
51.2. Constable Frick phoned Debra who was enquiring about VPD file # 21-147590, which had been a check-wellbeing call that Constable Frick had been stood down for and never attended as it was a medical only call.
51.3. Debra told Constable Frick that a proper investigation into [redacted] death needed to be completed.
51.4. Constable Frick queried [redacted] and found VPD file # 21-147590 to be the last documented interaction, with no deceased report had been completed.
51.5. Constable Frick created VPD file # 21-156836 to generate a missing person report.

51.6. At 14:17 hours, Constable Frick came across this investigation (21-148822), which had the deceased carded as [redacted], who was the entity that Debra had been speaking about.
51.7. Constable Frick called Debra back and informed her of the mistake, and that [redacted] was the deceased and the file had been thoroughly investigated.
51.8. Debra was not satisfied and wanted the drug dealers arrested for murder.
51.9. Constable Frick provided Debra with the correct file number and the lead investigator's number.

52. The "Police Statement – 10" Page authored by Sergeant Aaron Roed ("Sergeant Roed") stated:

52.1. On October 6, 2021, Sergeant Roed spoke with Debra on the phone regarding a number of messages she had left with the VPD since the death of he daughter.
52.2. Sergeant Roed had been informed by the VPD telecommunications unit that he mothers cell had contacted the VPD 113 times in the previous 30 days and she had left 39 voice messages to an unmonitored VPD line. Debra had left messages for officers to call her back, however due to her thick accent the names of the officer were unable to be understood.
52.3. Sergeant Roed called Debra, and had a conversation with her regarding the status of the investigation, he relayed the following information to her:
52.3.1. The file had been concluded as investigators were informed that the death was deemed "Accidental Death" by overdose by the BC Coroners Service.
52.3.2. Debra was very emotional and did not want to hear that the file had been concluded and wanted the VPD to investigate who gave her daughter the drugs.
52.3.3. Debra stated that she had contacted other VPD officers who also informed her of the same status of the investigation but was not willing to accept that conclusion.
52.3.4. Debra also had spoken to the BC Coroners service and was aware that the death was deemed not suspicious.
52.3.5. During the conversation Debra was understandably emotional and did not really want to hear about the status of the investigation.

52.4. At the end of the conversation Sergeant Roed re-affirmed with her about the status of the investigation and that he would notify the VPD CLU of the phone call and her concerns.
52.5. Sergeant Roed then contacted the Coroner liaison unit, who confirmed the death had been deemed not suspicious by the coroner. He notified the telecommunications unit and advised that the calls would likely continue.
52.6. Sergeant Roed believed that Debra would continue to reach out to VPD regarding the death of her daughter, and that it appeared that she did not

want to accept her daughter's death and wanted the person that had sold her daughter the drugs arrested for her death.

53. The "Miscellaneous Notes – 3" page authored by Detective Lui stated:

53.1. On September 1, 2021, Detective Lui was the on-call acting sergeant for homicide team 2.
53.2. At 2308 hours, Detective Lui had been phoned by A/Sergeant Cheng regarding the sudden death. A/Sergeant Cheng laid out the circumstances of the death.
53.3. A/Sergeant Cheng stated the concerns were the inconsistency of when the suite owner met the deceased and that the coroner was not attending.
53.4. Detective Lui agreed that these investigative steps should have been followed:
53.4.1. Contact Coroner again and explain will need body/head-to-toe examination done in-situ at scene before body removal, but still for police to determine whether suspicious or not based on assessment with Coroner.
53.4.2. A/V interview with the suite owner
53.4.3. Interview 911 caller (may be suite owner?)
53.4.4. CCTV, confirm last seen, activity/access to suite
53.4.5. If suspicious after assessing body and statements, will need to lock down suite for S/W

53.5. At 2352 hours, Detective Lui received an update from A/Sergeant Cheng:
53.5.1. The coroner wouldn't have been available until 0500 hours.
53.5.2. Patrol was to continue with CCTV canvass and interviews.
53.5.3. Ident was consulted to attend when the body was to be removed.
53.5.4. Homicide would be contact again should the circumstances be suspicious after the coroner attended, and interviews completed.

54. The "Miscellaneous Notes – 4" page authored by Criminal Records Clerk Cheryl Stewart("Stewart") stated:

54.1. On September 17, 2021, the criminal records unit received the file from Ident, who had taken the deceased's fingerprints.
54.2. The deceased was identified as [redacted] with FPS #782321D.
54.3. [redacted] was the legal name the deceased changed her name to.
54.4. On September 28, 2021, Stewart received an update from the detective [Sergeant Dodd believes this to be the Coroner Liaison Unit], that the correct name for the deceased should be [redacted].

55. The "Miscellaneous Notes – 5" page authored by Sergeant Teresa Buckoll ("Sergeant Buckoll") of the Missing Person and Coroner Liaison Unit, stated:

55.1. [redacted] had 0 PRIME, CPIC, CNI and LEIP entries.
55.2. BCDL was not on file, and had negative social media presence.
55.3. From Car 87, a possible name of [redacted] was identified.
55.4. Sergeant Buckoll believed the name to have been [redacted].
55.5. [redacted] had [redacted] PRIME entries, with an address listed as [redacted], and a phone number that wasn't answered.
55.6. Staff at this address informed Sergeant Buckoll that she had legally changed her name to [redacted], and was (at the time) in Vancouver Detox for treatment for addiction. Staff had not seen her for one week. The staff provided contact details for her mother.
55.7. Sergeant Buckoll further stated that she had been at detox on September 1, 2021 for alcohol use, and was living at [redacted], and she was followed by the overdose Outreach Team.

56. The "Miscellaneous Notes – 6" page authored by Detective Constable David Jakeway ("Detective Jakeway") stated:

56.1. On September 9, 2021, Detective Jakeway emailed the coroner explaining the mis-identification of the deceased, and that they believed her to be [redacted], and asked that the coroner service order up fingerprints. At the time of writing Detective Jakeway was awaiting results.

57. The "Miscellaneous Notes -7" page authored by Detective Constable Rebecca Matson ("Detective Matson") of the Coroner Liaison Unit stated:

57.1. On September 10, 2021, Detective Matson spoke with staff at Detox, and that there was no record of a female with the surname [redacted] or [redacted]. Staff confirmed that a female they knew as [redacted] was at detox from August to September 1.

58. The Miscellaneous Notes – 8" page authored by Detective Matson stated:

58.1. On September 10, 2021, Detective Matson obtained the fingerprints taken from the deceased, and turned them over to the VPD fingerprint coordinator.
58.2. The deceased was confirmed to be [redacted]. Housing had advised that she had gone through a legal name change to [redacted].
58.3. Detective Matson updated the entity of the deceased in the Prime file.

59. The "Concluding Remarks -1" page authored by Detective Matson stated:

59.1. Nothing appeared suspicious, no foul play. NOK was notified, property of the deceased was held at the property office to be released to the NOK, the Coroner advised, and body was transported to Glenhaven Funeral home.

60. The "CPIC Information -1" page created by Detective Matson was dated September 10, 2021 and was a next of kin notification request sent to Trail BC, RCMP to advised Debra Todorovic of her daughter's death. It explained the delay in the notification due to mis-identification, included brief details of the death and contact information for Detective Matson and the coroner.

61. The "CPIC Information -3" is dated September 10, 2021, and is from the Trail RCMP advising that the NOK notification had been completed.

62. The remaining pages, or those not captured in the above paragraphs were either boilerplate pages, or content that has no bearing on this OPCC investigation.

Review of Computer Aided Dispatch (CAD)

63. On July 7, 2022, Sergeant Dodd read VPD CAD call 21-148822 and learned the following:

64. On September 1, 2021, The summary for the call was:

64.1. Call number: VA21-148822 Date/In Time: 21-09-01 – 22:24:54
64.2. Status: Cleared
64.3. Initial type: Sudden Death
64.4. Final Type: Sudden Death
64.5. Priority: 3 Received by: Telephone
64.6. Address: [redacted] Community: Vancouver
64.7. Place: [redacted]
64.8. District:02 Zone: VAK

65. The initial remarks for the call were:

65.1. EHS OS // 35 YO FEM - OVERDOSE // NO PATIENT INFO // EHS CALLER: [redacted] // UKN IF VIC SERVICES REQ // NOTHING SUSP NOTED

66. The following times are entered into the call:

[redacted]

66.3. 22:32 - G51 COPIES THE CALL
66.4. 23:07 - VA2G51 HOLD OFF ON BODY REMOVAL.. GIVING MCS A CALL
66.5. 23:07 - VA2G92 COPY
66.6. 23:11 – (Dispatch) - CAR 10 IS AWARE
66.7. 23:43 - VA2G51 WAGON
66.8. 23:43 - VA2E62 FROM RENFREW/GRANDVIEW

66.9. 00:05 -VA2E62 X1 ON BOARD FOR ANNEX..
66.10. 00:11 - VA2G51 IS IT POSSIBLE TO GET THE CONTACT INFO FOR THE EHS UNIT THAT ATTENDED..
66.11. 00:15 – (Dispatch) (M): EHS CREW THAT ATTENDED IS NOW OFF SHIFT..ASKED EHS CHARGE SUPERVISOR TO CALL VA2G51
66.12. 01:38 - VA2G92 MALE HAS WANDERED OFF DECLINING OUR ASSISTANCE RETURNING HIM TO THE [redacted] ....CANCEL WAGON
66.13. 06:12 - VA2G72 CORONER OS AT 0607 HRS
66.14. 07:22 - VA2G72 BODY REMOVAL OS
66.15. 07:48 - VA2G72 CSP TO 2120
66.16. 22-09-16
66.17. 19:32 – (Dispatch) - (M): HAVE MOM OF DECEASED CALLING SNME TODOROVIC G1 DEBBY [redacted] , ,, DECEASED IS A SNME [redacted] ,, CLAIMS THAT WHEN SHE SPOKE TO ASSIGNED UNIT THEY WERE LAFFING ,AND THAT DEALERS SHOULD BE PUNSIHED, PERHAPS A NCO CAN CALL HER OT TRAIL RCMP CAN ATTEND AND CHECK ON HER
66.18. 20:41 – VA2G51 (VA2421 – Dodds, Tyler)- SPOKE WITH MOTHER DEBBY - UPSET AND WANTS FILE TO STAY OPEN AND INVESTIGATED RE: PEOPLE WHO GAVE HER DAUGHTER DRUGS ARE CRIMINALS AND SHOULD BE PUNISHED - ADVISED TO FOLLOW UP CONCERNS WITH CORONOR AND/OR CLU - APPRECIATED MEMBER HEARING HER OUT AND TAKING TIME TO SPEAK W HER.

67. The Units / Officers assigned to the call were:

67.1. VA2G92-BT VA3250 Thauli, Jo VA3194 Willson, Dispatch: 2021-Sep-01 22:28:59
67.2. VA2G51-PS VA3282 Cheng, Cla Dispatch: 2021-Sep-01 22:29:39
67.3. VA2G11-BT VA3224 Ash, Joell VA3358 Laviolett Dispatch: 2021-Sep-01 23:08:10
67.4. VA2G72-BT VA3247 Shirazi, A VA3308 Sandhu, G Dispatch: 2021-Sep-01 23:30:04
67.5. VA2E62-PT VA3235 Guy, Zacha Dispatch: 2021-Sep-01 23:43:29
67.6. VA2G72-PT VA3326 Lashar, Je VA3236 Haddon, G Dispatch: 2021-Sep-02 02:46:17
67.7. VA6R14-PT VA7328 Bauerfind, Dispatch: 2021-Sep-02 07:48:05
67.8. VA2G51-PS VA2421 Dodds, Tyl Dispatch: 2021-Sep-16 20:17:40

[See Attachment D_CPIC & PRIME]

Review of Coroner's Report

68. On May 31, 2022, Sergeant Dodd reviewed the coroner's report for of [redacted] (Mr. [redacted]), a coroner for the Province of British Columbia, for coroner's case number 2021-0397-0436 that was written on May 31, 2022 and learned, in part, the following:

68.1. A coroner's report was written on May 31 2022 for coroner's case number 2012-0397-0436 with regards to the death of [redacted] ([redacted]) that was reported on September 2, 2021.

68.2. The time of death was not listed, however the date of death was listed as September 1, 2021.

68.3. The medical cause of death was due to ethanol and mixed illicit, prescribed, and diverted drug toxicity.

68.4. The classification of death was accidental.

68.5. The investigative findings of the coroner's report included the following:

68.6. On September 2, 2021, the BC Coroner's Service was notified of a death at a Single Room Occupancy (SRO) building. The occupant of the room found [redacted]. Bystander CPR was attempted and BC EHS crew attended. EHS did not attempt resuscitation because [redacted] was clearly deceased.

68.7. [redacted]

68.8. Paraphernalia commonly used with illicit substance use was found in the room (white powder, naloxone, and tinfoil).

68.9. There was no evidence of traumatic injury or foul play.

68.10. [redacted]

68.11. [redacted]

68.12. [redacted]

68.12.1. [redacted]

68.12.2. [redacted]

68.12.3. [redacted]

68.12.4. [redacted]

68.12.5. [redacted]

68.12.6. [redacted]

68.12.7. [redacted]

68.13. [redacted]

69. [redacted]

[See Attachment D-Miscellaneous documentation

Review of Video Interview of [redacted]

70. On August 18, 2022, Sergeant Dodd reviewed the audio/video recorded interview of [redacted] ("[redacted]"). This interview had taken place on September 1, 2021 and had been conducted by Constable Thauli. Constable Thauli allowed [redacted] to tell his statement via free verse, however Mr. [redacted] statement was quite short. Constable Thauli asked a series of clarifying questions throughout the interview. The interview was 37 minutes and 42 seconds long. It is summarized as follows:

70.1. Constable Thauli provided introductions and rules. The interview was a voluntary witness interview and [redacted] was free to go.

70.2. [redacted] stated that he had fallen asleep, and woke up and attempted to wake up the deceased. He tried to pick her up, however was unable. He asked his neighbour to help carry her down the stairs. The neighbour couldn't.

70.3. [redacted] went downstairs, and asked staff to call 911.

70.4. [redacted] stated that he did not recall the deceased's name.

70.5. [redacted] had met the deceased in Victory Square Park at approximately 9:45 PM. They "hit it off" and had friendly conversation, talking about general life experience, etc. [redacted] initiated the conversation.

70.6. The pair talked about the future, and moving out of the DTES, and having a family. The conversation was about 15 minutes in length.

70.7. They discussed leaving the park, and going to [redacted] house to watch a movie and cuddle. [redacted] stated that she was receptive to that idea. [redacted] initiated this part of the conversation.

70.8. After leaving the park the pair went to [redacted] apartment, using the front entrance of the building.

70.9. [redacted] did not obtain her name, and if she did provide it, he couldn't recall it.

70.10. Once in the apartment, they put on a movie and cuddled. After a short time, [redacted] left to get some coolers from the Beer and Wine store On Abbott Street. The female stayed at his home.

70.11. When [redacted] returned, the female was asleep. [redacted] was worried and began to rock the female to wake her up, however she wouldn't stir. He attempted pick her up around the shoulders, and rouse her. He did this for approximately 10 minutes.

70.12. [redacted] believed she was asleep, however began to panic and went next door to get help.

70.13. [redacted] stated that she hadn't used any narcotics in front of him, and she appeared sober when they were at the park.

70.14. Constable Thauli re-iterated what had [redacted] had stated.

70.15. [redacted] stated that he had observed the female take a couple puffs of his crystal meth, but no other drugs were taken. The female had requested the drugs.

70.16. [redacted] went next door to his neighbour's suite, asking to help move the female out of the apartment. The neighbour wouldn't help, so [redacted] went downstairs to get help from staff.

70.17. [redacted] believed the female to be passed out, and was asking for help removing her. [redacted] took the office phone upstairs with him, with the staff member following.

70.18. [redacted] attempted to call 911, however couldn't get through. The staff member then called 911 and was successful in requesting an ambulance.

70.19. The ambulance arrived 15 minutes later. Nobody disturbed the female again before the paramedics arrived.

70.20. [redacted] appeared distraught at the end of the interview.

[See Attachment E_Photo and Video]

Witness Member Interviews

Sergeant Aaron Roed

71. On June 1, 2022, Sergeant Dodd conducted an audio recorded interview over the phone with witness member; Sergeant Aaron Roed. Sergeant Roed was named in Ms. Todorovic's complaint as one of the officer's she had spoken to over the phone. Sgt, Roed's statement can be summarized as follows:

71.1. Sergeant Roed is Constable Thauli's supervisor, however was not on duty on September 1, 2021.

71.2. Sergeant Roed has reviewed VPD file number 21-148822, and was aware that it surrounded the apparent overdose death of a female.

71.3. Upon review of the file, Sergeant Roed believed that Constable Thauli conducted a detailed investigation, and the matter was investigated fully, and that it appeared to have been an accidental overdose death.

71.4. Sergeant Roed became aware of the file on October 6, 2021, when his S/Sergeant advised that the VPD telecommunications unit had received 113 messages left on an unused phone number for the BET unit.

71.5. Sergeant Roed contacted the person that left those messages; Ms. Todorovic after reviewing VPD file # 21-148822.

71.6. Sergeant Roed stated that Ms. Todorovic was quite emotional regarding the investigation and would listen to Sergeant Roed, however

wasn't taking in what he had said. Sergeant Roed knew that she had already spoken with members regarding the file, and that they had said the same thing; the status of the investigation, and the fact that the death appeared to be from accidental overdose and that the file had been concluded.

71.7. Sergeant Roed stated that Ms. Todorovic wanted the police to go after the drug dealer that had sold her daughter the drugs, and the matter pursued as a homicide.

71.8. Sergeant Roed referred Ms. Todorovic to the VPD coroner liaison unit and the BC coroner's service, however believed she already had that information.

Constable Ali Shirazi

72. On September 7, 2022, Sergeant Dodd conducted an audio recorded interview of Constable Shirazi over the phone. Sergeant Ralph Kaisers was with Constable Shirazi as his union representative. The interview was summarized as follows:

72.1. On the evening of September 1, 2021 to the morning of September 2, 2021, Constable Shirazi was on duty in full uniform, and working with Constable Sandhu.

72.2. Constable Shirazi recalled being called by A/Sergeant Clayton Cheng to attend to the [redacted] Hotel at [redacted] to assist another unit with a sudden death.

72.3. Constable Shirazi recalled taking direction once on scene by A/Sergeant Cheng and was responsible for speaking with two staff members and conducting door knows on neighbouring suites to attempt to speak with some of the other residents.

72.4. Constable Shirazi obtained written statements from the two staff members, and believed their statements to be truthful and valid.

72.5. The staff members were the general manager; [redacted] and the front desk worker [redacted].

72.6. Constable Shirazi stated that [redacted] had stated that he was sleeping in his room in the [redacted], when [redacted] woke him up to assist with the death. [redacted] stated that [redacted], the tenant, apologized to [redacted] and stated that he wouldn't do anything to hurt him. [redacted] then advised what [redacted] had told him.

72.7. Constable Shirazi recalled that [redacted] had gone upstairs for something unrelated and that [redacted] had approached him for a wheelchair to help him move a dead body. [redacted] found this suspicious, and told [redacted] to call 911.

72.8. When asked about the section of [redacted] statement where he had observed [redacted] with a female on August 31, 2021 (the night before the death). Constable Shirazi recalls [redacted] making this comment, and stated that [redacted] has said [redacted] was with a black female. Constable Shirazi did not observe the deceased, and he believed that [redacted] hadn't either. Constable Shirazi wasn't sure if [redacted] believed the deceased and the black female to be one and the same.

72.9. Constable Shirazi did not believe there to have been any CCTV footage from the hallways, but left the lead investigator's business card with [redacted] and asked that he review the footage from the building and the timelines to see if there was anything suspicious. Constable Shirazi is unsure of the outcome of that. [redacted] was to review the footage when he woke up.

72.10. Constable Shirazi believed that the reason why the death was treated as suspicious was because of the comments [redacted] had made to [redacted] about the wheelchair, etc. Constable Shirazi had been aware that the lead investigator was going to interview [redacted] that night, and that Homicide investigators had been called.

72.11. Constable Shirazi stated that during his door knock canvass was fruitless.

Constable Clayton Cheng

73. On September 22, 2022, at 7:24 PM, Sergeant Dodd conducted an audio recorded interview of Constable Clayton Cheng ("Constable Cheng") over the telephone. Constable Cheng's union representative; Sergeant Kalvin Penner ("Sergeant Penner") was also on the line. Constable Cheng's interview was summarized as follows:

73.1. On September 21, 2021, Constable Cheng was on duty as the Acting Sergeant for the Beat Enforcement Team 2.

73.2. Constable Cheng was aware of the sudden death call [redacted] – the [redacted] Hotel. The call had come in from EHS and was initially not suspicious.

73.3. Constable Cheng received a call from Constable Brad Willson, who was the attending member. Constable Willson advised Constable Cheng that the deceased was a 35 year old female and that the story/timeline the tenant was telling attending members and what the staff was advising differed, and therefore Constable Willson thought the death suspicious.

73.4. Constable Cheng attended the scene.

73.5. Furthermore Constable Willson advised that there was no coroner available and that they would not be attending. The dayshift coroner would not begin their shift until approximately 5am.

73.6. Constable Cheng notified the duty officer and called the Major Crime Section – Homicide unit on call NCO; Detective Lawerence Lui to notify them of the call and ask for guidance.

73.7. Constable Cheng, the duty officer and Detective Lui developed a plan to secure the suite until the dayshift coroner came on duty for the coroner to assess if the death was suspicious, interview the suite owner, obtain statements from the building's staff, conduct a video canvass and attempt to interview other tenant's on the floor.

73.8. Constable Cheng assigned various members of his team to do these tasks.

73.9. At the end of his shift, Constable Cheng briefed the dayshift NCO and asked that he follow up with the investigation, obtain an EHS crew report, conduct more door to door knocks and obtain the video footage from the building.

73.10. Constable Cheng had no further actions related to this investigation. When he came on duty the following night, he was informed by Constable Willson that the coroner did not deem the death suspicious.

74. As the supervisor for the shift, Constable Cheng was not aware of any member breaching VPD policy or not investigating the death fully

<u>Constable Jeremy Lashar</u>

75. On October 4, 2022, Sergeant Dodd conducted and audio recorded interview of Constable Jeremy Lashar (Constable Lashar). Staff Sergeant Jason Chan was present during the interview as Constable Lashar's union representative. The interview can be summarized as follows:

75.1. On September 2, 2021, Constable Lashar was on duty in uniform, working in company of Constable Haddon. Constable Lashar had been called out by the VPD Emergency Operational Planning Section (EOPS) to provide guard duty on suite [redacted] in relation to a sudden death call.

75.2. At 2:30 AM, Constable Lashar and his partner took over containment / site security for the suite from two other officers. Constable Lashar was assigned remain on scene until the coroner arrived and conducted their investigation, or until he was relieved. Once the coroner had conducted their investigation, Constable Lashar was to update the Acting Sergeant.

75.3. At some point after 3 AM, the coroner arrived on scene and conducted their investigation. Constable Lashar recalled the coroner stating that there was no indication of foul play and the death appeared to have been caused by overdose.

75.4. Constable Lashar did not recall the coroner stating anything about the potential time of death.

75.5. After the coroner concluded their investigation, Constable Lashar informed the Acting Sergeant.

75.6. Constable Lashar then collected the deceased's valuables; A purse containing various cards, keys, paper and $150, as well as rings, and a necklace. Constable Lashar had these items tagged at the VPD property office for safekeeping to be turned over to the deceased's next of kin.

75.7. Constable Lashar remained on scene until global Body Removal attended and removed the deceased from the suite.

75.8. Constable Lashar secured the suite at approximately 7:30 AM, turned the keys over to staff, then left and wrote his evidence. He had no further information pertaining to this investigation.

Respondent Member Statements

Constable Jordan Thauli

76. On October 6, 2022, Sergeant Dodd conducted an audio recorded interview of Constable Jordan Thauli (Constable Thauli). Sergeant Ralph Kaisers was present during the interview as Constable Thauli's union representative. The interview began at 9:09 AM.

77. Constable Thauli provided a free-verse version of what he recalled. This was summarized as follows:

77.1. On the evening of September 1, 2021, Constable Thauli was on duty in full uniform and was assigned to general patrol duties with Beat Enforcement Team 2. Constable Thauli was in company of Constable Brad Willson.

77.2. Constable Thauli stated that at 10:24 PM, EHS called in a report of a sudden death of an unknown female at room [redacted]. EHS reported that the death did not appear suspicious.

77.3. At 10:28 PM, Constable Thauli and Constable Willson arrived on scene, and met with room [redacted] tenant; [redacted], who had called 911.

77.4. Constable Thauli stated that EHS was also on scene and advised that the female was clearly deceased, and that rigor had begun to set in on her neck, and she was cold to the touch.

77.5. [redacted]

77.6. Constable Thauli did not observe any signs of a struggle and there did not appear to be any signs of trauma to the body. Aside from tinfoil near the body, there was no other drug paraphernalia. Based off of Constable Thauli's experience, tinfoil is often used as an aide to take illicit drugs.

77.7. Constable Thauli recalled that the deceased had a hospital bracelet in the name of "[redacted]" on her wrist, and he recalled finding paystubs in her purse with the same name.

77.8. Constable Thauli then spoke with [redacted] on scene about what happened and who the deceased was. [redacted] advised him:

77.8.1. [redacted] stated that he had met the female that evening in Victory Square Park.

77.8.2. They had hit it off and agreed to go back to his room.

77.8.3. They had had a couple of coolers.

77.8.4. He stated that they had both had "2 puffs of jib" (Methamphetamine).

77.8.5. Shortly after that he stated that he passed out for 20 minutes and when he woke he discovered that the female wasn't breathing.

77.8.6. He tried to rouse her, lift her up and then attempted CPR before contacting 911.

77.9. Constable Thauli recalled speaking with staff member [redacted] ([redacted] was also a staff member). [redacted] advised that he recalled [redacted] had a female in his room the night before at approximately 6 PM.

77.10. Constable Thauli felt that with [redacted] stated that he had observed [redacted] with a female the night before and what [redacted] was telling police, there were inconsistencies in [redacted] version of events, specifically the timeline of when he met this female.

77.11. Constable Thauli stated that at that point, there needed to be more of an investigation, to determine what had actually happened.

77.12. The suite was secured for continuity of the unit and [redacted] was taken to the VPD police Annex to flush out the inconsistencies. Constable Thauli conducted a voluntary audio and video recorded witness interview of [redacted]. Constable Thauli stated that the statement was a voluntary witness statement, and that [redacted] was not under arrest, and wasn't being detained, and they were strictly treating him as the complainant and witness to the events.

77.13. Constable Thauli stated that there was no reason to believe that he was a suspect of any sort, however that some inconsistencies had been identified.

77.14. Constable Thauli believed that the inconsistencies could have been a fact that [redacted] had had a deceased female in his room, and that he could have been under a lot of stress and foggy on what had happened, and when they happened.

77.15. Constable Thauli recalled [redacted] stating:

77.15.1. [redacted] had met the female at Victory Square Park, where they developed a friendship and decided to go to his room to cuddle.

77.15.2. They got to his suite at approximately 10:04 PM.

77.15.3. He admitted to smoking methamphetamine.

77.15.4. [redacted] left to go to the liquor store at approximately 10:24 PM.

77.15.5. When he returned, he saw that the female was asleep, and attempted to rouse her.

77.15.6. He recalled that her eyes were open, and that she was not breathing.

77.15.7. [redacted] asked a neighbour for help rouse her, however that neighbour declined to assist.

77.15.8. At 10:40 PM, he went and spoke with [redacted]. [redacted] couldn't get through to EHS, so [redacted] called for him.

77.15.9. EHS arrived on scene 15 minutes later.

77.16. Constable Thauli stated that after speaking with [redacted], he was satisfied regarding the suspicious timeline that [redacted] gave, and based this off the fact that [redacted] was obviously distressed and traumatized.

77.17. Constable Thauli stated that [redacted] informed them that the female he had observed [redacted] with the night before was a black female, while the deceased was Caucasian. This fact ruled out the question of if [redacted] was with the deceased on August 31.

77.18. Constable Thauli stated that the coroner had attended and found that the death was likely an accidental overdose, and there was foul play, blunt force trauma or any signs of a struggle.

78. Sergeant Dodd then asked a few clarification points. Constable Thauli stated:

78.1. Constable Thauli found [redacted] to be lucid, truthful and genuine when he provided his statement, however he was visibly shaken.

78.2. Constable Thauli stated that the following investigative steps had been taken aside from interview [redacted]:

78.2.1. He and Constable Willson had notified their supervisor; Acting Sergeant Clayton Cheng of the suspicious nature of the file.

78.2.2. VPD Major Crime Section had been advised of the file.

78.2.3. The coroner was called about the file.

78.2.4. Written statements had been taken from Mr. [redacted] and Mr. [redacted].

78.2.5. A video canvass had been conducted.

78.3. Constable Thauli stated that the death itself wasn't suspicious, it was the divergence in the timeline from what [redacted] had stated, vs. what EHS and Mr. [redacted] had advised.

78.4. Constable Thauli stated that the only change in [redacted] story was that while interviewed at the police station he added that he had left the suite to get drinks from the liquor store. Constable Thauli stated that he believed this change occurred because they had provided [redacted] time to gather his thoughts.

78.5. Constable Thauli stated that he believed that the reason he treated the death as suspicious wasn't because he believed that the deceased had been victim of foul play, it was because of the inconsistencies in [redacted] timeline.

78.6. Constable Thauli was not present when the coroner attended.

78.7. Constable Thauli couldn't recall if he re-attended the scene or stayed at the annex to write his report after the interview.

79. Sergeant Dodd then asked about the phone call conversation the complainant alleged she had had with Constable Thauli, he stated the following:

79.1. He didn't recall the conversation at all, or her allegation that somebody laughed at her.

Constable Brad Willson

80. On September 22, 2022, at 6:58 PM, Sergeant Dodd conducted an audio recorded interview of Constable Brad Willson ("Constable Willson"). The interview took place over the phone. Constable Willson's union representative; Sergeant Penner was also present on the line. Constable Willson's interview was summarized as follows:

80.1. On September 1, 2021, Constable Willson was on duty working with Constable Jordan Thauli, conducting general patrol duties.

80.2. At 10:30 PM, the pair were dispatched to room [redacted] – the [redacted] Hotel, for a sudden death call. Constable Willson knows the [redacted] to be a male only SRO.

80.3. Constable Willson and Thauli arrived at approximately 10:36 PM.

80.4. They were met at the front by staff member [redacted], who advised them that the deceased was a female, and she was in the suite of a male named [redacted]. [redacted] believed that [redacted] had brought the female to his suite the night before – August 31.

80.5. When Constable Willson reached the floor, he discovered [redacted] sitting on the hallway floor with his head in his hands, and an EHS crew standing by.

80.6. The EHS crew pulled Constable Willson aside and advised him that things weren't adding up to what [redacted] was stating. The crew believed the female had been deceased longer than what [redacted] stated. [redacted] had stated to them that he had just met the female an hour previous, however rigor mortis in her jaw and lividity in her lower back had begun to set in.

80.7. Constable Willson asked [redacted] how he knew the female in his room, he stated that he had just met her in the park, and that he had met her approximately an hour prior to police and EHS arriving.

80.8. This timeline and what the EHS crew stated, caused Constable Willson to begin to suspect something was off.

80.9. Constable Willson then entered room [redacted], and discovered the female seated on the floor, with her upper body on a single bed that was in the left corner of the room. There was no signs of a struggle, or immediate signs of drug paraphernalia in the suite.

80.10. The female was Caucasian or Mixed-race, with a bandage on her forearm.

80.11. Constable Willson told Constable Thauli to hold the suite while he went and spoke with [redacted] again.

80.12. [redacted] told Constable Willson that at approximately 9:15 PM Clement told [redacted] that he had a girl in his room from overnight, and that she had passed out. [redacted] told Constable Willson that they had a policy that females couldn't stay overnight. Because of this [redacted] told [redacted] to get the female out of his suite. At 10:00 PM, [redacted] came back

downstairs and stated that he needed a wheelchair to remove the female from his suite and building, as he couldn't wake her. [redacted] told him the call 911.

80.13. After speaking with [redacted], the timeline, what [redacted] was saying and what the paramedics advised, Constable Willson believed the circumstances of the death to be suspicious. Constable Willson then called Acting Sergeant Clay Cheng to inform him of the suspicious nature of the female's death.

80.14. Constable Willson stated that there was some back and forth between him and Acting Sergeant Cheng with details of the investigation. Constable Willson believed this to be because Acting Sergeant Cheng was liaising with the duty officer and MCS Homicide.

80.15. Constable Willson then called the coroner service, who advised the only on duty coroner for the province was in [redacted] Lake and would not be attending that evening. And that they would dispatch body removal to take the body, and that the coroner service did not deem the death suspicious at that time.

80.16. Constable Willson did feel it was suspicious, so pressed the matter with his NCO. A plan was developed to hold the suite until the dayshift coroner came on duty.

80.17. Constable Willson and Constable Thauli were tasked with interviewing [redacted]. They took [redacted] to the VPD headquarters and conducted a voluntary witness interview of him. Constable Willson wasn't sure, but he believed that he monitored Constable Thauli interviewing [redacted].

80.18. Constable Willson recalled [redacted] story changing from what he had originally stated. [redacted] had at one point stated that he had left the suite to get alcohol. Constable Willson stated that he seemed nervous and that the timeline of the story seemed to jump. [redacted] admitted to smoking Methamphetamine that evening, however appeared lucid.

80.19. Constable Willson believed that a specialty unit would be doing some follow-up to verify [redacted] story.

80.20. After concluding the interview, Constable Willson and Thauli wrote the GO report up to date, and then ended their shift.

80.21. When he began his shift the following evening, Constable Willson ran the report and learned that the dayshift coroner attended and determined that the death was not suspicious.

[See Attachment G_Member Statements]

Review of Member Training Records

Constable Jordan Thauli

81. On October 12, 2022, Sergeant Dodd reviewed the VPD training records for Constable Thauli. Sergeant Dodd has included a list of courses / seminars that Constable Thauli has completed that may be relevant to this Police Act investigation. The courses are:

81.1. 2017-01-05 – Naloxone Training

81.2. 2017-01-31 – Crisis Intervention and De-escalation CPKN

81.3. 2017-02-02 – Crisis Intervention and De-escalation VPD

81.4. 2018-11-03 – CPKN Nalxone Training

81.5. 2020-02-22 – Fair and Impartial Policing

81.6. 2020-02-24 – Crisis Intervention and De-escalation VPD

81.7. 2020-02-25 - Crisis Intervention and De-escalation CPKN

81.8. 2020-02-26 – Evidence Based Risk Focused DV Course

81.9. 2020-04-25 – Assessing Risk Safety Planning DVACH Inv

81.10. 2020-11-10 – Trauma-Informed Policing

81.11. 2020-12-27 – Police and Autism

81.12. 2021-01-04 – Drug Investigative Techniques Course

Constable Brad Willson

82. On October 12, 2022, Sergeant Dodd reviewed the VPD training records for Constable Willson. Sergeant Dodd has included a list of courses / seminars that Constable Willson has completed that may be relevant to this Police Act investigation. The courses are:

[redacted]

[Attachment J_Member Training Records]

Policy

83. Sergeant Dodd reviewed the following sections of the VPD regulations and procedures manual:

    83.1. VPD 1.6.38 – Sudden Deaths

    83.2. VPD 1.7.6 – Major Crime Scene Responsibility

84. The basic Sudden Death Policy of the VPD (Section 1.6.38) was:

POLICY

All sudden deaths shall be thoroughly investigated to determine if there is any indication of criminality. Although the majority of sudden death investigations will be non-criminal in nature, the investigating members should always be mindful that a sudden death scene could be a crime scene and therefore appropriate investigative procedures and detailed documentation are required. When a sudden death has been deemed non-criminal in nature, police may remain to continue the sudden death investigation, as they are acting as agents for the coroner under the British Columbia *Coroners Act*.

Sudden death investigations are difficult events for all people involved, including witnesses, next-of-kin and emergency service workers. As such, these investigations must be treated with compassion and sensitivity. Members should be cognizant of cultural or religious considerations that may have great significance for the deceased or next-of-kin, and keep in mind that

associated practices should be allowed to take place as long as they do not interfere with the ongoing police or coroner investigation. Members should consider requesting the Victim Services Unit to attend to provide support and assistance to next-of-kin or witnesses when appropriate.

Depending on the circumstances, some sudden death investigations may be particularly challenging or distressing for members, and it may be appropriate to engage assistance from the Critical Incident Stress Management (CISM) Team. See RPM Section 1.7.20 Critical Incident Stress Management Team (CISM).

85. The procedure on how to investigate Sudden Death's was:

PROCEDURE

1. Upon receipt of a sudden death report, an available patrol unit will be assigned to investigate. If there are no units available, a supervisor shall make efforts to assign a two-member unit as soon as operationally feasible.
2. Patrol members will most often be the primary investigators for sudden deaths. It is preferable to have a two-member unit assigned to attend sudden death calls, but when no two member unit is available, a one-member patrol unit may be assigned as primary with a cover unit to attend the scene.
3. When it is established there is no indication of criminality or other suspicious circumstances, and next-of-kin are present the cover unit may, if appropriate, return to service and the assigned unit shall complete the investigation.
4. Members shall notify a supervisor of all sudden death incidents which are suspicious in nature or which involve criminality, suicide or accident.
5. If there are suspicious circumstances or indications of criminality, the supervisor shall ensure the scene is secured (see RPM Section 1.7.6 Major Crime Scene Responsibility) and notify the Duty Officer, who shall assess the situation and contact the on-call Homicide Unit supervisor when appropriate.
6. The supervisor shall also notify the Duty Officer of the following sudden deaths:
    a. The unexpected death of a child or infant;
    b. Any in-custody death;
    c. Any death or circumstances of death that may have a public profile requiring management of media issues;
    d. Any suspicious suicide; and
    e. A workplace or industrial accident death (See RPM Section 1.6.45 Workplace or Industrial Accidents).
7. The BC Coroners Service shall be notified as soon as practicable of every sudden death being investigated. The investigating member shall telephone the on-call coroner and supply the following information regarding the deceased, if known:
    a. Name and address;
    b. Date of birth;
    c. Next-of-kin;
    d. Family doctor;
    e. Name of hospital; and
    f. Other information as requested by the coroner.
8. Prior to the arrival of the coroner, the investigating members shall not move any items within the scene including the body of the deceased, unless it is necessary to make the scene safe, preserve the body, or any evidence.

9. Once the scene has been cleared by the coroner, all valuables may be left with a suitable next-of-kin; a signed receipt shall be obtained in the investigating member's notebook when the next-of-kin does not reside with the deceased. When next-of-kin are not present, all readily apparent valuables shall be removed from the body and secured at the Property and Forensic Storage Services building (PFSS) for safekeeping. Members shall also seize any valuables from the dwelling of the deceased, if they could easily be removed (e.g. money, jewelry) and secure these at the PFSS. See RPM Section 1.9.3 General Property Policy and Procedure. Members should be mindful that the powers to search the dwelling of the deceased for valuables when acting on behalf of the coroner is limited to a cursory search of readily visible items.
10. If the deceased is a renter, members shall ensure that the rental property manager secures the decedent's residence and personal effects until the administrator or executor of the estate, next-of-kin or public trustee takes control. Valuables shall be dealt with as in section 9. If no administrator, executor or next-of-kin can be located, members may advise the property manager to secure the rental property and/or belongings in accordance with the regulations under the Residential Tenancy Act (property managers may contact the Residential Tenancy Branch for guidance if required).
11. Where a sudden death occurs at a hospital, other than in an emergency ward, and there is no indication of criminality or suspicious circumstances, the hospital will notify the coroner directly. The coroner may request that police attend if they believe there is a need for police investigation.
12. Whenever photographs are required at the scene of a sudden death, they shall be taken by a member of the Forensic Identification Unit (FIU). If the coroner requests police take photographs, the coroner must attend the scene. When prescription medications are found at the scene of a sudden death and there are suspicious circumstances, the medications shall be treated as evidence. Consideration shall be given to examination of the containers by the FIU. Members shall liaise with Homicide Unit investigators and the coroner to assist in determining appropriate disposition of the prescription medication (for example, medication submitted to Health Canada for analysis or tagged for destruction depending on case-specific circumstances).
13. When drugs, other than prescription medication, are found at the scene of a sudden death, members shall comply with RPM Section 1.6.12(ii) Drug Handling Procedures to ensure they are handled, seized and/or secured in a safe manner.
14. Only the coroner can authorize the removal of remains from a scene. When the death is suspected to be a homicide, fire death or there are suspicious circumstances, the body of the deceased shall not be moved until direction is received from Homicide Unit investigators. In these cases, the body shall be sent to a location directed by the Homicide Unit investigators.

86. The Next of Kin Notification requirements of the VPD Policy were:

Next-of-Kin Notification

25. The identification of the deceased and notification of next-of-kin is the responsibility of the initial investigators and shall be completed in as timely a manner as practicable. The next-of-kin notification shall be conducted in person when possible. An indirect notification (e.g. by phone) is not recommended and is only acceptable when no practical alternative exists. Members shall document how the next-of-kin were identified and notified in the GO report.
26. Members may request the Victim Services Unit attends to provide support and assistance to next-of-kin or others who are present. See RPM Section 1.14.2 Victim Services Unit.

27. Where investigators from the Homicide Unit have been called to the scene of a sudden death investigation, the assigned patrol members shall seek direction from the Homicide Unit supervisor regarding notification of next-of-kin.
28. Where Homicide Unit investigators are assigned to investigate a death, it will be their responsibility to follow up with the next-of-kin to provide information when appropriate, and as further facts become known.
29. The cause of death can only be determined at the conclusion of the coroner's investigation. When information is requested by, or provided to, an outside jurisdiction or a next-of-kin regarding the cause of death, members are to advise that the information relayed is only a suspected cause until such time as there has been confirmation received from the coroner.
30. The circumstances of death may only be determined at the conclusion of the police investigation. When information is requested by, or provided to, an outside jurisdiction or a next-of-kin regarding the circumstances of death, members shall provide as much information as possible, while ensuring the integrity of the investigation is not compromised.
31. Members shall make every effort to ensure next-of-kin are notified prior to any media release. Members shall make every effort to ensure next-of-kin are notified prior to any media release.
32. Members conducting the notification shall provide the next-of-kin with the contact information for the Coroner's Liaison and the BC Coroners Service. In non-suspicious sudden death investigations, after the initial notification has been completed, it will be the responsibility of the BC Coroners Service to provide follow-up information to the next-of-kin if further facts regarding the death become known.
33. When next-of-kin reside in a neighbouring jurisdiction to Vancouver, the assigned members shall consider making the in-person notification themselves. When next-of-kin are located in a jurisdiction outside Vancouver, and it is not practicable for VPD members to do the next-of-kin notification, the assigned member shall:
    a. As soon as practicable, send a CPIC message on the "VA_NOK Notification" template to the appropriate police agency requesting assistance with the next-of-kin notification ensuring that suitable details and contact numbers are included, sufficient to allow the outside jurisdiction police agency to provide an adequate notification;
    b. Request that the next-of-kin notification be conducted in person in as timely a manner as possible; and
    c. Contact the outside police agency by telephone and ensure they are aware that a next-of-kin notification requiring timely attention has been submitted via a CPIC message.
34. Where a next-of-kin notification cannot be made in a timely manner by an outside jurisdiction, the investigating member shall consult with a supervisor to determine the appropriate manner in which to proceed. Where consideration is given to dispatching a VPD unit to another jurisdiction to conduct the in-person notification, the following shall be taken into account:
    a. Additional resources which may be required at the notification site such as Victim Services, emergency medical assistance or other police members for security and safety;
    b. Staffing deployment and resources available to respond to calls for service in the City of Vancouver; and
    c. Location of the other jurisdiction in relation to Vancouver.
35. In the event that the deceased is a foreign national and there is no next-of-kin available in Canada, or a next-of-kin cannot be readily contacted, the supervisor shall

consider contacting the appropriate embassy/consulate and request assistance. If the embassy/consulate is unable/unwilling to assist, or cannot be contacted, members may be required to make the notification via telephone when no other options are available. Members shall consider the use of a translator to assist in cases where a language barrier exists.

36. Members shall make investigative efforts to identify the deceased in cases where the identity is unknown. These efforts may include the use of CPIC or PRIME (using identifying marks, etc.) an area canvass, or other means available. If, after the completion of the initial investigation, the deceased is unidentified or next-of-kin is not located and advised, then the case shall be referred to the Coroner's Liaison. The Coroner's Liaison shall continue the investigation and work with the coroner to identify the deceased and notify next-of-kin.

87. The Report Writing requirements for a Sudden Death Investigation were:

Old Policy (at time of Ms. [redacted] death)

Report Writing

b. All sudden death investigations shall be fully documented in a GO report and shall include the actions taken and any follow-up required by the CLU. Members will also document if the next-of-kin notification was successful and the identity of the next-of-kin.

c. The following key criteria, although not exhaustive, must be documented in a sudden death investigation report:

a. The Scene:

- Obtain a detailed description of the scene including a hand drawn diagram;
- Temperature;
- If inside, windows open/closed;
- Damage or any signs of a struggle;
- Signs of forced entry;
- Doors/windows secured;
- Items that appear misplaced or missing; and
- Anything else that is noteworthy.

b. The Deceased:

- Obtain a detailed description of the deceased person;
- Clothing;
- Position and location of the body; and
- Injuries or other circumstances of the body.

c. Possible Cause of Death:

- Evidence that may indicate the cause of death;
- Medical records;
- Medical conditions;
- Medications;
- Signs of drug use; and
- Self-disclosure letters.

d. Witnesses: Provide an interview summary for the witnesses on scene and, if possible, the last person to see the deceased alive;

e. Area Canvas: Conduct a canvass for video or audio recording of the circumstances of the death;

f. Electronic Devices: Consider placing electronic devices in a "radio frequency proof container" to prevent loss of data as per Section 1.9.19: Seizing Digital and Electronic Devices;

g. Nature of the Death: Document the factors or rationale as to why the death is not suspicious in nature.

Current Policy (As of July 2022)

Report Writing

37. All sudden death investigations shall be fully documented in a GO report, including a Sudden Death details page, and shall include the actions taken and any follow-up required by the Coroner's Liaison. Members will also document if the next-of-kin notification was successful and the identity of the next-of-kin. Concluding Remarks / Conclusion Block pages are not required by patrol members; the Coroner's Liaison will review every sudden death investigation and conclude the file as appropriate.
38. The following key criteria, although not exhaustive, should be documented in a sudden death investigation GO report when appropriate or when known:
    a. The Scene:
        - Document a detailed description of the scene;
        - Temperature (if relevant);
        - If inside, windows open/closed;
        - Damage or any signs of a struggle;
        - Signs of forced entry;
        - Doors/windows secured;
        - Items that appear misplaced or missing; and
        - Anything else that is noteworthy;
    b. The Deceased:
        - Document a detailed physical description of the deceased, including visible tattoos and their location (particularly in cases where the identity of the deceased is unknown);
        - Clothing;
        - Position and location of the body; and
        - Injuries or other circumstances of the body;
    c. Possible Cause of Death:
        - Evidence that may indicate the cause of death;
        - If known, any available medical records, known medical conditions, or medications;
        - Signs of drug use; and
        - Self-disclosure letters;
    d. Witnesses: Provide an interview summary for the witnesses on scene and, if possible, the last person to see the deceased alive;

e. Area Canvass: Conduct a canvass for video or audio recording of the circumstances of the death;

f. Electronic Devices: When the identity of the deceased is unknown, members may consider tagging mobile devices at the PFSS to assist follow-up investigators in identifying the deceased;

g. Nature of the Death: Document the factors or rationale as to why the death is or is not suspicious in nature;

h. Next-of-kin: Document how the next-of-kin was identified and notified.

39. In cases where the original GO report was not identified with a UCR code of "Sudden Death" on PRIME, but the circumstances changed to that of a sudden death, the attending unit must update the UCR code in the PRIME report to reflect that a sudden death has occurred. In cases where conduct of the investigation has been taken over by a specialty unit, the follow-up investigator will be responsible for updating the UCR code in the PRIME report and/or notifying the Coroner's Liaison directly.

If members have already submitted the GO report they may call the Transcription and CPIC Support Unit for assistance in making corrections.

[Sergeant Dodd has left out the portions of the policy surrounding Suicide, Expected/Planned Home Deaths, and Custody of Remains]

Case Law

88. Sergeant Dodd identified the following cases/rulings that have weight or bearing on this alleged misconduct and subsequent investigation:

88.1. *F.H. v McDougall (2008, SCC)*

88.2. *Faryna v Chorny (1952, BCCA)*

88.3. *R. v. Sturko (2013, ABPC)*

88.4. Hawkes v. McNeilly, (2016, ONSC)

88.5. Allen v. Alberta (2013, ABCA)

88.6. OPCC 2011-6912 - COP

[See Attachment H_ Case-law and VPD Policy]

Further Investigative Steps Requested by OPCC

89. On October 18, 2022, Sergeant Dodd spoke with OPCC analyst Anahita Mittal (Ms. Mittal). Ms. Mittal advised that she had spoken to her supervisor who requested that further investigative steps be taken regarding this investigation. Verbally Ms. Mittal requested the following:

89.1. Interview Det. Lui and Det. Matson regarding their involvement.

89.2. Speak with the Respondent Members about their experience with sudden death investigations.

89.3. Determine what came of the door knock canvass and video canvass.

90. On October 20, 2022, Sergeant Dodd requested a 30 business day extension to have time to follow-up with these requests.

91. On October 27, 2022, Sergeant Dodd received the 30 day extension.

92. On October 28, 2022 Sergeant Dodd conducted audio recorded interviews of Det. Lui and Det. Matson.

Detective Lawerence Lui

93. On October 27, 2022, at 9:53 AM, Sergeant Dodd conducted an audio recorded interview of Detective Constable Lawrence Lui (Detective Lui). Staff Sergeant Jason Chan was present for the interview as Detective Lui's representative. Sergeant Dodd asked Detective Lui a series of questions as stated below. Sergeant Dodd would reiterate what Detective Lui had stated, and then ask clarification questions. The answers were:

93.1. On the evening Of September 1, to the morning of September 2, 2021, Detective Lui was the on-call Acting Sergeant for the homicide unit.

93.1.1. Detective Lui recalled receiving a call from an A/Sergeant in patrol late in the evening in regards to a sudden death investigation at an SRO. Detective Lui recalled the A/Sergeant had two concerns with the investigation. The first was that the patrol officers had called the corner's service who would not be attending the call, and the second was that patrol had identified an individual who they had believed had been associated with the deceased, and that person had given a timeline of events, and there was some concern whether or not that was consistent with other witnesses accounts of the timeline.

93.2. Detective Lui gave the following direction to the A/Sergeant:

Coroner

93.2.1. Advised the A/Sergeant to contact the coroner again, as Detective Lui felt they were apprised of all of the circumstances, and that this was probably a case where they should be attending, and this may be an assumption on the coroner's part based off the information they initially received, that they could close this file without attending.

Patrol

93.2.2. In the meantime Detective Lui suggested that Patrol should take some investigative steps, namely attempts to corroborate the various statements.

93.2.3. He asked that they ensure they take statements from all of the witnesses they had identified.

93.2.4. Obtain a voluntary audio/video statement from the male that was associated with the deceased.

93.2.5. Detective Lui also suggested that they take conventional steps such as a neighbourhood canvass to see if there were other witnesses from the floor and a video canvass if that was possible.

93.3. Detective Lui stated that he was familiar with the outcome of the investigation because the following morning he opened the PRIME file to add his MN page. Furthermore in preparation for the OPCC investigation interview, Detective LUI read the GO report and file. Following the conversation with the A/Sergeant that night, he had called Detective Lui back to discuss the coroner's attendance, and it was explained that the initial coroner had declined to attend as they were in a different part of the province, the A/Sergeant had made arrangements to secure the suite and lock it down until the dayshift coroner could arrive in the morning and do the examination. Detective Lui was aware that a coroner did physically attend the scene as requested, and the result of that was there was a conclusion made that this was consistent with an overdose death and that the file was transferred to the coroner's service to retain custody and that no criminality was suspected.

93.4. Detective Lui stated that he has been a police officer for approximately [redacted] years, with [redacted] of those as a homicide investigator. With an initial rotation of [redacted] years, then [redacted] years in a forensic identification role where he also participated in sudden death and homicide investigations, and then a further [redacted] years in homicide.

93.5. In Detective Lui's policing experience, it is common for police to rely on the Coroner's assessment at a sudden death, and have the file turned over to the coroner service for further investigation. In every sudden death investigation the coroner has to be contacted, it is a very consultive and collaborative process. Once the information is relayed to the coroner, the police officer, whether it is a patrol officer or homicide investigator, has to make a determination whether or not there is any foul play suspected or ruled out, it is ultimately up to the coroner to determine the

cause of death. The body is always under the purview of the coroner, a physical examination of the body would require the coroner's approval. Once a case falls within their domain the police authority is acting as an agent for the coroner. The police have to rely on the coroner for their expertise in assessing a scene and the circumstances, and a consensus has to be reached together. Unless there is something contentious or facts that police don't think that the coroner has grasped or if there is a perception that they are misapprehending certain facts or circumstances, then the discussions with the coroner would escalate with what the police opinion is.

93.6. Sergeant Dodd asked, in this specific incident, the coroner came to the scene, they determined that it looks like a sudden death / overdose investigation, at that point the police investigation was closed? Detective Lui agreed with that assessment.

Detective Rebecca Matson

94. On October 28, 2022, at 12:16 PM, Sergeant Dodd conducted an audio recorded interview of Detective Rebecca Matson, of the VPD Coroner Liaison unit. S/Sergeant Jason Chan was present for the interview as Det. Matson's union representative. Detective Matson was familiar with the sudden death investigation that this OPCC complaint stemmed from.

94.1. Detective Matson stated that Ms. [redacted] body had been fingerprinted on September 10, 2021 and that same day she was identified. Through police database queries Detective Matson was able to identify Ms. Todorovic, of Trail, BC, as Ms. [redacted] next of kin. Detective Matson sent a CPIC request to the Trail BC, RCMP detachment to conduct a next of kin notification. Detective Matson received notification later that day that the notification had been completed.

94.2. Detective Matson recalled speaking on the phone with Ms. Todorovic, however did not recall the discussion.

95. After completing the interview with Detective Matson, she informed Sergeant Dodd that she and Sergeant Buckoll (Ret.) had submitted suggested changes to the VPD sudden death policy to the VPD Planning and Research unit, at some point early in 2021. One of the key changes was the wording under the "report writing" header, specifically the portion where the old policy stated "...**must** be documented....", and the new policy stated "...**should** be documented..." Detective Matson stated that the old policy was too strict in the reporting requirements, as each sudden death should be assessed individually and all of the steps listed under the report writing may not be applicable to the individual investigation. Sergeant Dodd could not find out when these changes occurred, however the policy was last updated on July 20, 2022.

96. On November 1, 2022, after Sergeant Dodd asked for some clarification, Ms. Mittal emailed the following investigative steps:

96.1. Follow up with the respondent members to canvass on :

96.1.1. their experience with sudden deaths,

96.1.2. what they reported up and to whom following obtaining Mr. [redacted] audio recorded statement and the Coroner's assessment

96.1.3. what direction they received and from whom

96.1.4. their awareness of the results of the door knocks and CCTV canvass

96.1.5. whether they were aware of the sign in sheet referenced in the GO

96.2. I note that Acting Sergeant Cheng states in his interview that he briefed the day shift NCO and requested that he follow up with the investigation including to obtain an EHS crew report, conduct more door to door knocks and obtain the video footage from the building. Could you please interview the day shift NCO to canvass on their involvement and specifically on the tasks Sergeant Cheng briefed on for follow up.

97. On November 4, 2022, Sergeant Dodd emailed Constable Cheng to ask who the dayshift NCO was. He advised that it was Constable Steven Bhatti, who has since quit the VPD. Sergeant Dodd conducted some further inquiries and learned that Constable Bhatti has quit the VPD and moved from the province, and has not left forwarding contact information. Sergeant Dodd determined that interviewing Constable Bhatti was not integral to this investigation, and therefore did not make attempts to speak with him.

98. Sergeant Dodd received Constable Thauli and Constable Willson's replies to their experience with sudden death investigations (Constable Thauli spoke to the three other requested steps).

Constable Thauli

99. On December 2, 2022, Constable Thauli provided his follow-up statement:

100. I have been employed as a Police Constable with the Vancouver Police Department since May [redacted]. From August [redacted] until December [redacted] I was working with a field training officer during my block 2 of training. I have been operational (post academy) since March [redacted]. Since March [redacted], I have been working in the Downtown Eastside for the Department's Beat Enforcement Team 2. During my time on the road, I have been either the primary or secondary

investigating officer in 19 sudden death investigations. These do not include sudden death investigations that I have attended as a cover officer. These investigations have occurred in either the Vancouver's Downtown Eastside area, or the VPD's district 2, which surrounds the Downtown Eastside and moves further East to Boundary Road. All sudden death investigations I have investigated have been the result of an accidental overdose due to drugs, or were caused by medical distress. Drug overdose deaths are a common occurrence in the Downtown Eastside due to the illicit drug trade.

101. After comparing [redacted] initial verbal statement and that of staff, and PC's noting inconsistencies, PC's advised the on duty Acting Sergeant, A/Sgt 3282 CHENG of the investigation and inconsistencies. A/Sgt CHENG then liaised with the on duty Inspector and the VPD's major crimes section. The plan was to maintain continuity of the unit until the Coroner arrived. PC's THAULI and WILLSON were also tasked with interviewing [redacted] to get more details on the incident.

102. Following [redacted] audio recorded statement, PC THAULI advised [redacted] not to return to his unit for 24 hours as it was still occupied by the deceased and police until the Coroner arrived. PC THAULI reiterated to [redacted] that he was being treated as a witness in this investigation. PC THAULI advised A/Sgt CHENG that he was satisfied with [redacted] statement, and did not believe there to be any criminality in the death based on [redacted] statement.

103. Police were to hold the unit until the Coroner attended to conduct their investigation. PC THAULI was not involved or on scene when the Coroner or body removal arrived. As per PC 3326 LASHAR's statement, who was guarding the unit, BC Coroner [redacted] arrived on scene at 0207 hours and deemed the death not suspicious and a likely overdose by drugs. A/Sgt 2913 HURST was advised of this and body removal was contacted. The body was transported to Glen Haven Funeral Home.

104. PC THAULI was not involved in conducting door knocks to any units. PC THAULI also had no involvement in viewing or seizing CCTV footage. At this time I cannot speak to these tasks or the results.

105. PC THAULI was made aware of the male that was seen with [redacted] on September 01 at approximately 0825 hours. However, PC THAULI does not recall viewing a sign in sheet.

Constable Willson

106. On November 9, 2022, Constable Willson provided the following statement regarding his experience investigating sudden deaths:

106.1. I, Cst 3194 Bradley Willson have been employed in the Downtown Eastside of the City of Vancouver BC as part of Beat Enforcement Team

2 since March [redacted]. In that time I have attended approximately 40 or more Sudden Deaths where I have been the primary patrol member on scene.

In my experience with Sudden Deaths the first thing I look for is for anything suspicious regarding the initial scene. If nothing in my opinion is deemed suspicious I advise my NCO and then contact the coroner to brief them or have them attend.

If I believe there is anything suspicious surrounding the death of the deceased or of the scene, I immediately back out of the area, contain the scene and advised my NCO of the situation to advise our specialty sections (ie. Major Crimes) who, in my experience, attend if they deem it suspicious or won't attend if not.

ANALYSIS

107. In order to determine whether Constable Thauli and Constable Willson may have committed the alleged misconduct set out above, it is necessary to examine:

107.1. Definition of the alleged misconduct;

107.2. The standard of proof;

107.3. A criteria to assess credibility and reliability;

107.4. The available evidence;

107.5. The essential elements of the alleged misconduct with relevant case law; and

107.6. The issues of law.

Definition of the alleged misconduct

108. *Neglect of Duty* has been defined in the *Police Act* as follows:

108.1. Neglect of Duty pursuant to section 77(3)(m)(ii) of the Police Act by neglecting, without good or sufficient cause, to promptly and diligently do anything that it is one's duty as a member to do.

Standard of Proof

109. The standard of proof used in this investigation, as in all civil matters, is proof on the balance of probabilities. One of the most important judgements on this issue comes from *F.H. v McDougall (2008, SCC)*.

110. The *McDougall* judgement set out the test that will apply (para 49):

110.1. *In civil cases there is only one standard of proof and that is proof on a balance of probabilities. In all civil cases, the trial judge must scrutinize the relevant evidence with care to determine whether it is more likely* than not that an alleged event occurred.

111. The judgement also included the following caution (para 40):

111.1. *Context is all important and a judge should not be unmindful, where appropriate, of inherent probabilities or improbabilities or the seriousness of the allegations or consequences.*

112. Finally, and most importantly, the judgement stated that "*evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test.*" (para 46).

Standard to Assess Credibility and Reliability

113. In assessing the credibility of statements made during the investigation, Sergeant Dodd relied upon a test established in *Faryna v Chorny (1952, BC CA)*:

113.1. *The credibility of interested witness, particularly in cases of conflict of evidence, cannot be gauged solely by the test of whether the personal demeanour of the particular witness carried conviction of the truth. The test must reasonably subject his story to an examination of its consistency with the probabilities that surround the currently existing conditions. In short, the real test of the truth of the story of a witness in such a case must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions... Again a witness may testify what he sincerely believes to be true, but he may be quite honestly mistaken. For a trial Judge to say "I believe him because I judge him to be telling the truth", is to come to a conclusion on consideration of only half the problem. In truth it may easily be self-direction of a dangerous kind.*

113.2. *The trial Judge ought to go further and say that evidence of the witness he believes is in accordance with the preponderance of probabilities in the case and, if his view is to command confidence, also state his reasons for that conclusion. The law does not clothe the trial Judge with a divine insight into the hearts and minds of the witnesses. And a Court of Appeal must be satisfied that the trial Judge's finding of credibility is based not on one element only to the exclusion of others, but*

is based on all the elements by which it can he tested in the particular case.

114. Assessments of credibility are essential in marking findings of fact, especially where there are two opposing versions of events. Such assessments are based on many factors but rely heavily on reason and common sense. As noted by the Alberta Provincial Court judgement in *R. v. Sturko ABPC 211* at paragraph 15:

114.1. *Many factors go into a credibility assessment. Importantly, the court should look first to the content of the witness's evidence alone. Is it internally consistent or inconsistent? Is the witness's evidence logical and make some semblance of sense or is it fanciful and defy any sense of logic or common sense, given the events the witness is describing?...*

115. The court in R. v. *Sturko* also noted the importance of assessing the witness while giving verbal testimony:

115.1. *[15]....Does the witness focus on the question and reply directly to the question or does the witness make gratuitous comments that maintain a certain theme directed at minimizing culpability or demonstrating the witness in a positive light?*

115.2. *[16] The form of witness's evidence is also an important factor that goes into a credibility assessment. Is the witness responsive or unresponsive to the questions? Does the form of the witness's testimony change as between examination in chief and cross examination? Does the witness answer questions freely or in an evasive manner? Is the witness flip and dismissive or are questions answered with care and consideration? Is the witness open or confrontational with counsel? Does the witness try to manage the flow of evidence or do they answer questions faithfully?*

115.2.1. *[17] Credibility also includes an assessment of the reliability of a witness's testimony. Credibility is the determination of whether a witness is credible in the sense of testifying without animus or favour and whether the witness is attempting to misrepresent the facts or attempting to freely explain what occurred.*

115.3. In *R. v. Sturko*, the Court also recognized the need to turn one's attention to the issue of reliability in relation to a witness's statement and or testimony:

115.4. *Credibility also includes a consideration of the reliability of a witness's testimony. Reliability involves an assessment of whether the witness's evidence accurately recounts the events testified to. Reliability involves a consideration of the ability to recall, the ability to recount that memory, the ability of the witness at the time of the event to absorb what*

occurred, the level of cognitive awareness of the witness at the time of the incident, including sobriety, trauma, surprise, fatigue or other mental impairment.

The Available Evidence

116. Sergeant Dodd has assessed and reviewed all available evidence, which included:

116.1. The Registered Complaint and Notice of Admissibility;

116.2. Ms. Todorovic's statement;

116.3. A review of the General Occurrence report and CAD;

116.4. A Review of the Coroner's report;

116.5. A review of the interview of Mr. [redacted];

116.6. The interview/statement of six witness officers;

116.7. The interview/statement of two respondent officers;

116.8. A review of the respondent officer's training records;

116.9. Policy and Case-law

Issues of Law and Essential Elements of the Alleged Neglect of Duty

Duties and Authorities of a Police Officer

117. The Vancouver Police Department is governed by the Vancouver Police Board under the authority of the British Columbia Police Act. The Vancouver Police Department is empowered to enforce the criminal law, the laws of the Province, municipal by-laws and to generally maintain law and order within the City of Vancouver.

118. The common law duties of a police officer that are consistently recognized in the Canadian courts are:

118.1. To preserve the peace.

118.2. To prevent crime.

118.3. To protect life and property.

118.4. To enforce the law.

118.5. To apprehend offenders.

119. There are also statutory duties placed upon police officers in the BC Police Act. Section 26(2) of the act states that the duties and functions of a municipal police department are, under the direction of the municipal police board, to:

119.1. Enforce, in the municipality, municipal bylaws, the criminal law and the laws of British Columbia.

119.2 Generally maintain law and order in the municipality

119.3. Prevent Crime.

Neglect of Duty - Defined

120. The definition of the alleged misconduct identified in this file is: *Neglect of Duty* pursuant to section 77(3)(m)(ii) of the *Police Act* which is, neglecting, without good or sufficient cause, to promptly and diligently do anything that it is one's duty as a member to do.

121. Sergeant Dodd reviewed the Conclusion of Proceedings for OPCC file 2011-6912 in which former PCC Stan Lowe expressed the view that the analysis for Neglect of Duty in British Columbia involves three statutory elements pursuant to a plain reading of section 77(3)(m)(ii) of the Police Act:

121.1. The determination of whether a duty exists in the circumstances and, if so, the nature of the duty;

121.2. Whether or not the conduct of the officer constitutes neglect of that duty; and, if so,

121.3. Whether there exists good and sufficient cause to excuse the neglect.

122. In the Conclusion of Proceedings for OPCC file 2011-6912 former PCC Stan Lowe provided the following clarifying points with regards to his perspective on the analysis of Neglect of Duty:

122.1. Good or sufficient cause: objective standard of what a reasonable police officer with similar training, knowledge, skills and experience would have done in the same circumstances.

122.2. The spectrum of performance spans from when a member clearly takes no action, and fails to perform any aspect of their required duties, through to a level in which a member performs their required duties in an exemplary manner. The difficulty in determining whether misconduct has occurred lies in the middle of the spectrum and must be resolved through

the application of the objective standard of reasonableness in terms of an Officer's conduct.

123. The leading case for general neglect would be *Hawkes v. McNeillly, 2016 ONSC, 6402* Paragraph 30 states "To constitute neglect of duty, the impugned conduct must include an element of willfulness in the police officer's neglect or there must be a degree of neglect which would make the matter cross the line from a mere job performance issue to a matter of misconduct."

124. Similarly a decision-maker must also consider the mental element necessary to establish misconduct, since section 77(3)(m)(ii) of the Police Act does not specify the mental element. The leading court judgment in Canada concerning the required mental element to make a finding of police misconduct – in the absence of language in the legislation specifying the mental element – is the decision of the *Alberta Court of Appeal in Allen vs. Alberta Law Enforcement Review Board 2013 ABCA 187 at paragraphs 32-37*, leave to appeal dismissed, 5 December 2013 (SCC). The court rejected the view that "a Charter breach is ipso facto a disciplinary offence, because it would mean that mere errors in judgment or carelessness would inevitably rise to the level of discreditable conduct". The Court of Appeal also concluded: "While police discipline may not require a full level of mens rea, and negligence may in some instances amount to a disciplinary offence, there *must be some meaningful level of moral culpability in order to warrant disciplinary penalties.*"

125. In defining *Neglect of Duty* Sergeant Dodd reviewed the Merriam-Webster online dictionary definition of "negligent", which is:

125.1. Failing to exercise the care expected of a reasonably prudent person in a like circumstance.

Assessment

Neglect of Duty Allegation

Were Constable Thauli and Constable Willson negligent in their duties to adequately investigate the death of Ms. [redacted]?

126. In order to assess whether or not *Neglect of Duty* occurred, Sergeant Dodd applied the following "three part test":

126.1. Was there a duty?

126.2. Was this duty neglected?

126.3. If so, was there good and sufficient cause?

Test 1: Was there a duty?

127. In Assessing whether Constable Thauli and Constable Willson had a duty to investigate the sudden death of Ms. [redacted], Sergeant Dodd considered the following evidence:

128. In order to make a determination on the issue outlined in the allegation of police misconduct, it is necessary to first consider whether Constable Thauli and Constable Willson were acting in the lawful execution of their duties as police officers.

128.1. Sergeant Dodd reviewed the CAD and General Occurrence Report for VPD file # 21-148822. Both of which confirmed that Constable Thauli and Constable Willson were on duty as police officers and serving the city of Vancouver as such.

128.2. In their interview/statements, both Constable Thauli and Constable Willson stated that they were on duty and in uniform when assigned to investigate Ms. [redacted] death.

128.3. Considering the totality of the information set out above, Sergeant Dodd holds no doubt that both Constable Thauli and Constable Willson were on duty and working in a partnership, and were assigned to investigate the sudden death.

129. Sergeant Dodd reviewed the VPD regulation and procedures manual to determine the policy set out for members of the VPD when conducting a sudden death investigation. Based off of this policy, members of the VPD, have a duty to investigate most deaths that occur outside of a hospital (exceptions are expected/planned home deaths).

130. After reviewing the CAD call for VPD file # 21-148822 Sergeant Dodd learned the following:

130.1. The file was initiated on September 1, 2021, at 10:24 PM.

130.2. The initial call type was carded as a "Sudden Death"

130.3. The location was [redacted] – [redacted] Hotel

130.4. The Initial Remarks for the call were: "BC EHS called 911 – Police, and reported " EHS OS // 35 YO FEM - OVERDOSE // NO PATIENT INFO // EHS CALLER: [redacted] // UKN IF VIC SERVICES REQ // NOTHING SUSP NOTED"

130.5. Under the Units/Officers assigned, it stated that the first unit to be assigned was at 10:28 PM, and was Constable Thauli and Constable Willson.

Test 1: Assessment

131. When assessing all of the information listed above Sergeant Dodd holds that Constable Thauli and Constable Willson were on duty on September 1, 2021. Constable Thauli and Constable Willson were assigned to investigate the report of a sudden death at suite [redacted], and as such were to follow the policies related to such an investigation as laid out in the VPD regulations and procedures manual.

132. Based off this information Sergeant Dodd finds that Constable Thauli and Constable Willson did have a duty to investigate the death of Ms. [redacted], and that they conducted this duty in a timely manner.

Test 2: Was this duty neglected?

133. In assessing whether or not Constable Thauli and Constable Willson neglected their duty to fully investigate the death of Ms. [redacted], Sergeant Dodd considered the following evidence:

134. VPD file # 21-148822 general occurrence report "narrative";

134.1. Constable Thauli and Constable Willson as a partnership, attended to the scene within eight minutes of the call from EHS. EHS did not think the death was suspicious.

134.2. When Constable Thauli and Constable Willson discovered discrepancies in the timeline of events, between Mr. [redacted] initial verbal statement and what the staff at the [redacted] Hotel reported, they treated the death as suspicious.

134.3. Constable Thauli and Constable Willson notified their supervisor (A/Sergeant Cheng) of the suspicious information surrounding the death.

134.4. Constable Thauli and Constable Willson identified the deceased female as "[redacted]", via a hospital bracelet and paystubs. She was described in the report as "Caucasian female, 5'8", 120lbs, with short brown hair, wearing a dark green halter style top, black leggings, black socks, and light brown sandals with a pink purse wrapped around her right left wrist".

134.5. Constable Thauli and Constable Willson notified the BC coroner service, and decided to have the suite locked down until the dayshift coroner could attend in person.

134.6. Constable Thauli and Constable Willson conducted an audio and video recorded interview of Mr. [redacted] to obtain more details about the death.

134.7. Constable Shirazi conducted interviews of both staff members; Mr. [redacted] and Mr. [redacted]. Constable Shirazi conducted a video canvass.

134.8. In Constable Shirazi's interview of Mr. [redacted], Mr. [redacted] stated that the female he had seen Mr. [redacted] with the evening before was a black female.

134.9. In Constable Shirazi's interview of Mr. [redacted], Mr. [redacted] stated that Mr. [redacted] had advised him that he had met the deceased an hour earlier in a park.

134.10. Constable Thauli wrote that the "disposition" for the file was that the suite was being held until the coroner arrived to assess the deceased, that A/Sergeant Cheng had been notified, as well as the duty officer and MCS Homicide.

135. VPD File # 21-148822 General Occurrence "Police Statement-2 – Constable Willson":

135.1. After arriving on scene, Constable Willson spoke with the EHS crew, who advised that the deceased had the start of rigor mortis in her jaw and lividity in her low back. This caused the EHS crew to suspect the deceased had been dead longer than what Mr. [redacted] had claimed.

135.2. After determining that the timeline surrounding the death was suspicious, he informed his supervisor and phoned the coroner service.

136. VPD File # 21-148822 General Occurrence "Police Statement-3 – A/Sergeant Cheng":

136.1. At 10:48 PM, A/Sergeant Cheng was called by Constable Willson and Constable Thauli, that the death they were investigating had become suspicious. A/Sergeant Cheng attended the scene.

136.2. A/Sergeant Cheng phoned the duty officer and then MCS Homicide and devised a plan to move forward:

136.2.1. The suite would be held until the dayshift coroner arrived.

136.2.2. A video canvass would be conducted.

136.2.3. An audio and video recorded interview of Mr. [redacted] would be conducted.

136.2.4. Two staff members Mr. [redacted] and Mr. [redacted] were to be interviewed.

136.3. A/Sergeant Cheng then liaised with the dayshift NCO to inform them of the status of the investigation.

137. VPD File # 21-148822 General Occurrence "police statement-4 Constable Lashar":

137.1. Constable Lashar held the suite until the coroner arrived. The Coroner advised the death was not suspicious, that the deceased likely died the evening before and that it appeared to be an overdose.

137.2. The coroner authorized the removal of the body.

138. VPD File # 21-148822 General Occurrence "police statement-8 Constable Thauli":

138.1. Constable Thauli wrote that he learned of the coroner's finding that the death was not suspicious, and that the file could be closed.

138.2. The named "[redacted]" did not exist on police data bases, so the file was forwarded to the VPD Coroner Liaison Unit.

139. VPD file # 21-148822 General Occurrence "miscellaneous notes – 3 Detective Lawrence Lui":

139.1. Detective Lui was contacted by A/Sergeant Cheng. Detective Lui provided guidance for the patrol members. If the coroner deemed the death suspicious, that they were to locked down the suite and contact MCS homicide again.

140. VPD file # 21-148822 General Occurrence "Miscellaneous notes-5 Sergeant Teresa Buckoll":

140.1. As the Sergeant in charge of the coroner liaison unit, Sergeant Buckoll conducted checks on the name "[redacted]" with the goal of identifying a next of kin. All police and social media data bases were negative for that name.

140.2. Car 87 (mental health car) advised that a possible name could be "[redacted]". Another possible name was "[redacted]".

140.3. Sergeant Buckoll phoned the address on file, and staff advised that [redacted] had legally changed her name to [redacted], and that she was currently in Vancouver Detox, and being monitored by the overdose outreach team.

141. VPD file # 21-148822 General Occurrence "Miscellaneous notes-6 Detective Jakeway":

141.1. Detective Jakeway called the coroner to inform them of the mis-identification, and to have fingerprints of the deceased taken.

142. VPD file # 21-148822 General Occurrence "concluding remarks - Detective Matson":

142.1. Detective Matson wrote that nothing in the investigation appeared suspicious and that the next of kin had been notified.

143. Sergeant Dodd reviewed the Coroner report authored by Mr. [redacted], a coroner for the Province of British Columbia and learned:

143.1. The date of the death was September 1, 2021.

143.2. The medical cause of death was due to ethanol and mixed illicit, prescribed, and diverted drug toxicity.

143.3. The classification of the death was accidental.

143.4. There was no evidence of traumatic injury or foul play.

143.5. Fentanyl and Hydromorphone were detected at a lethal level

143.6. Mr. [redacted] classified the death was accidental and made no recommendations.

144. Sergeant Dodd reviewed the interview of Mr. [redacted] conducted by Constable Thauli on September 1, 2021 and learned:

144.1. Mr. [redacted] stated that he had met the deceased in a park at 9:45 PM, they had a 15 minute conversation and they became friends, then went to Mr. [redacted] residence.

144.2. The pair put on a movie and cuddled, and smoked methamphetamine. After a short time Mr. [redacted] left the residence to get alcohol, and when he returned the female was asleep and he couldn't rouse her. He attempted to wake her for approximately 10 minutes, before seeking the help of neighbors and staff at the building. Eventually he attempted to perform first aid and then called 911 (the ambulance arrived 15 minutes later).

144.3. Upon questioning by Constable Thauli, Mr. [redacted] stated the deceased appeared sober when in the park, and he did not see her take any drugs other than the methamphetamine that he also smoked, which the female had requested.

145. Sergeant Dodd reviewed Constable Thauli's statement and learned the following:

145.1. When Constable Thauli first arrived on scene he observed a Caucasian female laying half on/ half off a bed, and that there were no signs of a struggle or trauma to the body.

145.2. Through various means, Constable Thauli identified the deceased as "[redacted]", and believed her to be that person.

145.3. Constable Thauli observed tinfoil beside the deceased and associated tinfoil with drug use.

145.4. Constable Thauli wrote that he spoke with Mr. [redacted] in the hallway and obtained a brief verbal statement of what had happened. He then spoke with Mr. [redacted] who provided a different timeline from what Mr. [redacted] had stated. Furthermore the female that Mr. [redacted] had seen Mr. [redacted] with the evening before was black.

145.5. It was because of the difference in timeline that Constable Thauli felt the death may be suspicious, and Mr. [redacted] needed to be questioned further.

145.6. Constable Thauli notified his supervisor of the suspicious nature of the death. He was aware that his supervisor was taking the appropriate RPM steps in regards to a sudden death.

145.7. Constable Thauli then conducted a video recorded interview of Mr. [redacted] and clarified what had happened, and that Mr. [redacted] appeared lucid and truthful in his answers.

145.8. Constable Thauli held that the death itself wasn't suspicious, it was Mr. [redacted] timeline that was questioned.

145.9. Constable Thauli was not present when the coroner attended.

146. Sergeant Dodd reviewed the statement provided by Constable Willson and learned the following:

146.1. When Constable Willson arrived on scene, he spoke with the EHS crew who advised that the deceased was already showing signs of rigor and lividity, and that it might not match what Mr. [redacted] was saying.

146.2. Constable Willson went into the room and described the deceased as Caucasian or mixed-race. There were no signs of trauma or a struggle.

146.3. Constable Willson spoke with Mr. [redacted], who stated that at 10:00 PM, he said Mr. [redacted] had told him that he had had a girl in his room overnight and that she had passed out and he couldn't wake her. He

came back down a short time later and asked for a wheel chair, and then ultimately called 911.

146.4. Given what Mr. [redacted], Mr. [redacted] and the EHS crew were advising, Constable Willson believed the death to be suspicious and treated it as such.

146.5. Constable Willson notified his supervisor and the coroner service.

146.6. Constable Willson became aware that his supervisor had spoken with Homicide Unit and developed a plan until the coroner would arrive and assess the death.

146.7. Constable Willson then assisted with the interview of Mr. [redacted] and helped with the report.

146.8. When returning to shift the following day, Constable Willson learned that the coroner had attended and determined that the death was not suspicious.

147. Sergeant Dodd reviewed the statement provided by Constable Cheng and learned:

147.1. Constable Cheng was the acting supervisor the night of the sudden death investigation.

147.2. Constable Cheng stated when he was advised by Constable Willson the details of the deceased, and that the story/timeline of Mr. [redacted] verbal statement aroused suspicion. Constable Cheng then attended the scene.

147.3. Constable Cheng knew the coroner was advised, and that they could not attend until the following morning.

147.4. Constable Cheng notified the duty officer and the on call Homicide supervisor of the suspicious nature of the death. Between the three they devised a course of action.

147.5. Constable Cheng arranged for the suite to be locked down until the coroner attended.

147.6. Constable Cheng assigned Constable Shirazi to conduct interviews of the two staff members of the building, along with door knocks and to conduct a video canvass.

147.7. Constable Cheng liaised with the dayshift supervisor for further follow-up should it be required.

147.8. Constable Cheng stated that once his shift started the following evening, he was informed by Constable Willson that the coroner had determined the death to not be suspicious.

148. Sergeant Dodd reviewed the statement provided by Constable Shirazi and learned the following:

148.1. Constable Shirazi was directed to attend the scene to assist with the investigation by A/Sergeant Cheng.

148.2. Constable Shirazi conducted interviews of staff members: Mr. [redacted] and Mr. [redacted]. Constable Shirazi felt the staff members were truthful in their statements. [The statements themselves are detailed above].

148.3. Constable Shirazi conducted door knocks at the neighboring suites, with either no answer, or the tenant not willing to assist police.

148.4. Constable Shirazi asked that Mr. [redacted] review the building's CCTV footage (he did not know if any existed) in the morning when he woke up, and contact the lead investigator if the footage revealed anything suspicious.

149. Sergeant Dodd reviewed Constable Lashar's statement and learned the following:

149.1. Constable Lashar was called out on overtime to contain the suite until the coroner arrived.

149.2. At approximately 3:00 AM, the coroner arrived on scene and conducted their investigation. The coroner advised that there was no indication of foul play in regards to the death, and it appeared to be an overdose.

149.3. Constable Lashar then had the deceased property tagged at the VPD property office as per policy.

150. Sergeant Dodd reviewed Detective Lui's statement and learned the following:

150.1. Detective Lui advised A/Sergeant Cheng to call the coroner service back and stress that they should attend the call.

150.2. Detective Lui suggested that patrol interview Mr. [redacted] and the staff members, conduct door knocks and a video canvass.

150.3. Detective Lui learned that the coroner attended and had determined that the death was not suspicious. In his policing experience,

in cases such as this it is common for the police to rely on the coroner's findings, and that in this specific case, once the coroner determined the file wasn't suspicious, the police investigation was concluded.

151. Sergeant Dodd spoke with Detective Matson who advised the VPD policy had been revised around the report writing requirements for sudden death investigations.

Test 2: Assessment

152. To assess whether Constable Thauli and Constable Willson neglected their duty to fully investigate Ms. [redacted] death, Sergeant Dodd relied on the steps laid out in the VPD policy on sudden death investigations, *Alberta Court of Appeal in Allen vs. Alberta Law Enforcement Review Board 2013* ABCA 187 at paragraphs 32-37, Hawkes v McNeilly, 2016 ONSC Paragraph 30 and the *Conclusion of Proceedings for OPCC file 2011-6912* drafted by former PCC Stan Lowe.

153. Sergeant Dodd submits that Constable Thauli and Constable Willson did fulfill their duties to adequately investigate the death of Ms. [redacted], despite Ms. Todorovic's allegation that they hadn't. Sergeant Dodd based this determination on the following:

153.1. Constable Thauli and Constable Willson, who were working as an Operation Division partnership promptly arrived on scene at the location of the death once dispatched by Ecomm. This fulfilled the first two steps laid out in the VPD policy – Sudden Death Procedure:

153.1.1. Upon receipt of a sudden death report, the E-Comm dispatcher shall assign an Operations Division unit to investigate. If there are no units available, the dispatcher shall advise a Patrol Supervisor of the holding call.

153.1.2. Operations Division members shall ordinarily investigate sudden deaths. A minimum of two members shall be present. When a one-member unit is assigned, a cover unit shall also be assigned.

153.2. After speaking with Mr. [redacted], Mr. [redacted] and EHS, both Constable Thauli and Constable Willson became suspicious of the timeline that Mr. [redacted] presented, the partnership notified their supervisor; A/Sergeant Cheng. This fulfilled step four of the VPD Sudden death policy – Procedure:

153.2.1. Members shall notify a Patrol Supervisor of all sudden death incidents which are suspicious in nature, or which involve suicide or accident.

153.3. As the death occurred after hours, A/Sergeant Cheng notified the Duty officer and the on call MCS Homicide supervisor. This fulfilled step five and six of the VPD Policy on Sudden Deaths Procedure:

153.3.1. After regular hours, a Patrol Supervisor shall advise the Duty Officer, who shall assess the situation and contact the on call Homicide Supervisor.

153.4. Constable Willson notified the coroner's office of the sudden death. This fulfilled step eight of VPD policy – Sudden Death Procedure:

153.4.1. The Coroner's Office shall be notified as soon as practicable of every sudden death being investigated. The investigating member shall telephone the Coroner's Office and supply the following information regarding the deceased:

153.4.2. a. Name and address;
153.4.3. Date of birth;
153.4.4. Next-of-kin;
153.4.5. Family doctor;
153.4.6. e. Name of hospital; and
153.4.7. f. Other information as requested by the coroner.

153.5. A/Sergeant Cheng assigned members to secure the suite until the dayshift coroner could attend and conduct their investigation. This fulfilled step nine of the VPD policy – Sudden Death Procedure:

153.5.1. Prior to the arrival of the Coroner, the investigating members shall not move any items within the scene including the deceased's prescription medications and pill bottles.

153.6. After the coroner arrived and determined that the death was not the result foul play, Constable Lashar had Ms. [redacted] belonging tagged at the property office. This fulfilled step ten of the VPD policy – Sudden Death Procedure:

153.6.1. Once the scene has been cleared by the Coroner, all valuables shall be left with a suitable next-of-kin and a signed receipt shall be obtained in the investigating member's notebook. When next-of-kin are not present, all readily apparent valuables shall be removed from the body and placed in the Property Office. Members shall also seize any valuables from the dwelling of the victim, if they could easily be removed (e.g. money, jewelry).

153.7. Constable Thauli and Constable Willson initially identified the deceased as "[redacted]", based off of the hospital bracelet and paystubs. Queries of that name on police data bases were fruitless, so they forwarded the file to the coroner liaison unit for follow-up. Sergeant

Buckoll and Detective Matson conducted further investigation into the identity of the deceased and ultimately obtained fingerprints from the coroner service. The same day the true identity of the deceased was learned by the coroner liaison unit, and Ms. Todorovic was identified as the next of kin, Detective Matson requested via CPIC message, that the RCMP attend her home in person and conduct a next of kin notification. The notification was for Ms. Todorovic to contact the VPD or the coroner's office for details. This fulfilled the requirements of the "next-of-kin notification" section of the VPD policy – Sudden Death:

153.7.1. The identification of the deceased and notification of next-of-kin is the responsibility of the initial investigators and shall be completed in as timely a manner as practicable. The next-of-kin notification shall be conducted in person. An indirect notification (e.g. by phone) is not recommended and is only acceptable when no practical alternative exists. Identification shall be made by next-of-kin, other relatives, close friends or others, in that order. Where no one can identify the deceased, identification may be temporarily made by documents among the effects. The method of identification is to be shown in the report.

153.7.2. The cause of death can only be determined at the conclusion of the Coroner's Investigation. When information is requested by, or provided to, an outside jurisdiction or a next-of-kin regarding the cause of death, members are to advise that the information relayed is only a suspected cause until such time as there has been confirmation received from the Coroner.

153.7.3. Members conducting the notification shall provide the next-of-kin with the contact information for the CLU and the BC Coroners Service. In non- suspicious sudden death investigations, after the initial notification has been completed, it will be the responsibility of the BC Coroners Service to provide follow up information to the next-of-kin if further facts regarding the death become known.

153.7.4. When next-of-kin reside in a neighbouring jurisdiction to Vancouver, the assigned members shall consider making the notification themselves. When next-of-kin are located in a jurisdiction outside Vancouver, and it is not practicable for VPD members to do the next-of-kin notification, the assigned member shall:

153.7.4.1. As soon as practicable, send a CPIC message to the appropriate police agency requesting assistance with the next-of-kin notification ensuring that suitable details and contact numbers are included;

153.7.4.2. Request that the next-of-kin notification be conducted in person in as timely a manner as possible; and

153.7.4.3. Contact the outside police agency by telephone and ensure they are notified that a next-of-kin notification requiring timely attention has been submitted via a CPIC message.

153.8. Constable Thauli stated in his interview that he was aware that Mr. [redacted] had seen Mr. [redacted] with a black female on the evening of August 31, 2021 and that Ms. [redacted] was clearly Caucasian. Sergeant Dodd found that this difference was significant, in that clearly Mr. [redacted] raised questions in regards to what Mr. [redacted] had reported to police, based from the fact that he believed the deceased to be the black female from the night before.

153.9. Sergeant Dodd reviewed the initial statement provided by Mr. [redacted] and the video recorded interview conducted by Constable Thauli and found that there were discrepancies between the two stories, namely that he first stated he woke up and found her unresponsive, and the second was that he went to the store and returned home to find her unresponsive. Constable Thauli believed this to be due to the traumatic event that Mr. [redacted] had gone through. Based off of Sergeant Dodd's [redacted] year policing career, where he has investigated hundreds of violent and traumatic events, he agreed with Constable Thauli's belief. Witnesses statements often change or morph over time as they recall events.

153.10. Sergeant Dodd also believed this to be true for Mr. [redacted] recalled timeline of events. It was clear to Sergeant Dodd that Mr. [redacted] had not correctly recalled the time he met Ms. [redacted], to when they came home to when he found her deceased.

Mr. [redacted] stated that he met her at 9:45 PM, in the park, had a 15 minute conversation, and that they then went back to his house where they hung out for 10 minutes, smoking methamphetamine. Mr. [redacted] then stated he went to the store for 15 minutes, and returned to find her unresponsive, and then went to obtain help, before ultimately calling 911. This would put the time that Mr. [redacted] called 911 between 10:45 and 11:00 PM.

Mr. [redacted] reported that at 9:15 PM, he had spoken with Mr. [redacted], who at that point stated he had a female in his room, and that she was unresponsive. EHS had attended, assessed the scene, and reported the call to police at 10:24 PM.

Sergeant Dodd queried the timeline for when rigor mortis sets in on the National Library of Medicine (US) website. Based on the definition listed below, and that Constable Thauli reported that rigor had just begun to set in on the deceased's jaw, that the death likely occurred roughly two hours before police arrival (8:30 PM or so).

153.10.1. Rigor mortis appears approximately 2 hours after death in the muscles of the face, progresses to the limbs over the next few hours, completing between 6 to 8 hours after death. Rigor mortis then stays for another 12 hours (till 24 hours after death) and then disappears.

It is clear to Sergeant Dodd that Mr. [redacted] was incorrect in his recollection of the timing for when he met Ms. [redacted], however was only incorrect by approximately an hour to two hours.

Sergeant Dodd also relied on Constable Lashar's "Police Statement page" in that he wrote the attending coroner had verbally advised that the death likely occurred earlier in the evening.

153.11. In Constable Thauli's occurrence report, he detailed the state of the room and how the deceased was situated. Constable Thauli conducted a video recorded interview of the witness; Mr. [redacted], to delve into the inconsistencies of his story and what Mr. [redacted] had first stated to Constable Willson in the hallway. Constable Shirazi conducted further detailed statements of Mr. [redacted] and Mr. [redacted] to flush out their statements. Constable Shirazi also asked Mr. [redacted] to review the CCTV footage, if any existed, the following day to confirm what Mr. [redacted] had stated. Constable Shirazi also conducted door knocks of the neighboring suites.

153.12. While Sergeant Dodd recognized that under the "report writing" title of the sudden death policy at the time, it stated that a diagram must be drawn, room temperature recorded, and other such details, Sergeant Dodd found that police members in this instance covered all of the pertinent steps based on why they had suspicion surrounding this death. They noted the state of the room and how Ms. [redacted] was situated. They interviewed three civilian witnesses. They conducted a neighbor canvass and conducted a CCTV canvass.

153.13. Sergeant Dodd further recognized that members could have conducted follow-up the following day with Mr. [redacted] on the status of the CCTV footage, however found that Constable Shirazi asked Mr. [redacted] to notify the investigating officer IF he found anything suspicious. Furthermore, when Constable Thauli and Constable Willson arrived back at work the following day, they learned that the coroner had deemed the death not suspicious. This took away their legal authority to seize any possible video footage, as there was no reason to suspect that a crime had been committed. Had they obtained the footage from the staff at the [redacted] Hotel, they could have potentially been accused of beaching another section of the *Police Act*. The same is true of the interview of Mr. [redacted]. It was a voluntary interview, and police had no reason to detain or arrest him or otherwise force his participation. Had Constable Thauli or

Constable Willson held Mr. [redacted] or interrogated him, they could have potentially breached his *Canadian Charter Rights*, or another section of the *Police Act*.

153.14. In sudden death investigations such as Ms. [redacted], where the cause of death isn't readily apparent to be nefarious in nature, police officer's in British Columbia act as a an agent of the Coroner Service. In this instance when the Coroner determined that Ms. [redacted] death was not suspicious, it took the legal authority away from the assigned investigators to carry on. Unless the death was readily apparent to be from wrongdoing and the coroner was missing that point, the police would not question the determination of the attending coroner.

153.15. Furthermore, the VPD policy has been changed since this incident to address these types of specific issues. To state a member "must" conduct specific steps, even though they are completely irrelevant to the specific situation, was counterproductive. The policy was altered to state "should", simply to allow the flexibility and leeway for members to assess each investigation as it presented itself.

154. Sergeant Dodd then assessed the mental element of neglect as laid out in *Alberta Court of Appeal in Allen vs. Alberta Law Enforcement Review Board 2013 ABCA 187 at paragraphs 32-37.* Specifically:

154.1. The court rejected the view that "a Charter breach is ipso facto a disciplinary offence, because it would mean that mere errors in judgment or carelessness would inevitably rise to the level of discreditable conduct". The Court of Appeal also concluded: "While police discipline may not require a full level of mens rea, and negligence may in some instances amount to a disciplinary offence, there *must be some meaningful level of moral culpability in order to warrant disciplinary penalties."*

154.2. Sergeant Dodd cannot in good conscience find that Constable Thauli and Constable Willson made any errors in judgement or carelessness, or that they were negligent in their duties to a "Meaningful level of moral culpability". In fact Sergeant Dodd found the opposite. That they conducted a thorough, fulsome and detailed investigation into an apparent overdose death when one thread of doubt aroused their suspicion. Sergeant Dodd based this finding on his experience of investigating dozens of sudden deaths in his years in patrol and from his time as an investigator in the VPD Major Crime Section.

155. To assess the willfulness component of a neglect of duty allegation, Sergeant Dodd also relied on Hawkes v. McNeilly, 2016 ONSC, Paragraph 30, specifically:

155.1. To constitute neglect of duty, the impugned conduct must include an element of willfulness in the police officer's neglect or there must be a degree of neglect which would make the matter cross the line from a mere job performance issue to a matter of misconduct.

155.2. Again, Sergeant Dodd found that Constable Thauli and Constable Willson believed they had, and in fact did, investigate the death of Ms. [redacted] to a more than adequate degree. Therefore the element required to prove they were willfully negligent, on either police officer's part, does not exist. They both believed that they were following the required policies and best practices when investigating the sudden death, there was no deliberate action or inaction taken by either member that would constitute neglect.

155.3. In fact upon reviewing all the steps taken by Constable Thauli and Constable Willson, Sergeant Dodd not only could not identify a matter of misconduct, but couldn't even identify any issues related to their job performance.

156. Lastly Sergeant Dodd then assessed the file using the guidelines laid out in the Conclusion of Proceedings for OPCC file 2011-6912 by former PCC Stan Lowe, specifically:

156.1. Good or sufficient cause: objective standard of what a reasonable police officer with similar training, knowledge, skills and experience would have done in the same circumstances.

156.2. The spectrum of performance spans from when a member clearly takes no action, and fails to perform any aspect of their required duties, through to a level in which a member performs their required duties in an exemplary manner. The difficulty in determining whether misconduct has occurred lies in the middle of the spectrum and must be resolved through the application of the objective standard of reasonableness in terms of an Officer's conduct.

157. Sergeant Dodd held that another reasonable officer, with similar training, knowledge, skills and experience would have investigated the sudden death in a similar fashion and come to the same conclusion. Constable Thauli and Constable Willson clearly took action investigating this death, and aside from not recording a few irrelevant reporting steps laid out in the VPD policy, performed their duties in an "exemplary manner".

Test 3: Was there good and sufficient cause?

158. As Sergeant Dodd found that Constable Thauli and Constable Willson did not neglect their duty, this test is moot.

Conclusion of Analysis

159. While Sergeant Dodd recognized that Ms. [redacted] death was tragic, and Ms. Todorovic has every right to be heartbroken about it, Sergeant Dodd did not find that Constable Thauli, Constable Willson or any other member of the Vancouver Police Department were negligent in their duties.

160. Constable Thauli and Constable Willson had their suspicions aroused regarding Ms. [redacted] death based off what Mr. [redacted], Mr. [redacted] and the EHS crew had advised. They both followed all necessary VPD policy and procedure in their investigation, and ultimately obtained adequate clarification on Mr. [redacted] story.

161. The Coroner conducted their own independent investigation, and came to the determination that Ms. [redacted] died on September 1, 2021 from an accidental overdose and there was no foul play suspected.

162. Upon review of the investigation, Sergeant Dodd found that there is no reason to believe that Ms. [redacted] death was the result of anything other than an unfortunate accidental overdose.

163. Ms. Todorovic has stated multiple times that she felt her daughter had been lured into this suite, and that she was the victim of foul play, however there was no physical evidence that would indicate that being the case. Furthermore Ms. Todorovic wanted the people that had provided her daughter the drugs that ultimately killed her to be either charged with murder or dealt with in harsher terms. While Sergeant Dodd respected and sympathized with that desire, it was not possible to prove the essential elements related to homicide for charge approval without very specific requirements met, which did not exist in this incident.

CONCLUSION

164. Upon review of all the available evidence, Sergeant Dodd submits that the evidence with respect to the allegation is not clear, convincing and cogent to satisfy the balance of probabilities test with respect to the allegation of *Neglect of Duty* pursuant to section 77(3)(m)(ii) of the *Police Act*.

165. Sergeant Dodd did not identify any other behavior from Constable Thauli or Constable Willson, or other officers that would amount to any additional misconduct.

166. Therefore, Sergeant Dodd recommends that the alleged misconduct of Neglect of Duty against Constable Thauli and Constable Willson be **unsubstantiated**.

ATTACHMENTS

The following attachments to the investigation pertain to the information gathered during the investigation of this *Police Act* complaint:

Attachment "A":	Complaint Form
Attachment "B":	OPCC Documentation
Attachment "C":	Complainant Material
Attachment "D":	CPIC & PRIME
Attachment "E":	Photo and Video
Attachment "F":	Member Training Records
Attachment "G":	Member Statements
Attachment "H":	Case Law and Policy
Attachment "I":	Miscellaneous Documents

Respectfully submitted,

Sergeant 2282 Doug Dodd
Professional Standards Section
Vancouver Police Department