OPCC File No. 2020-18123

IN THE MATTER OF THE *POLICE ACT*, R.S.B.C. 1996, c. 367

AND

IN THE MATTER OF A DISCIPLINE PROCEEDING UNDER SECTION 124

AND

IN THE MATTER OF ALLEGATIONS OF MISCONDUCT

AGAINST

CONSTABLE [redacted]

OF THE VANCOUVER POLICE DEPARTMENT

DISCIPLINE AUTHORITY'S REASONS UNDER SECTION 125(1)(b)

(Supplement to Form 3)

TO:	Constable [redacted] c/o Vancouver Police Department Professional Standards Section	(Member)
AND TO:	Mr. Kevin Westell	(Member's Counsel)
AND TO:	Mr. Clayton Pecknold	(Commissioner)

1. EXECUTIVE SUMMARY

[1] This is a decision following a discipline proceeding in relation to four allegations of misconduct arising from a next-of-kin notification performed by the member on June 25, 2019.

[2] The recipient of the next-of-kin notification filed a complaint with the Office of the Police Complaint Commissioner and a *Police Act* investigation was conducted by a member of the Vancouver Police Department ("VPD"). The investigator issued a final investigation report recommending a finding of no misconduct. That report was reviewed under Section 117, resulting in this discipline proceeding under Section 124.

[3] The evidence filed on the discipline proceeding consists of the final investigation report and the evidence and records referenced in it; a further investigation report created under Section 132 and the evidence and records referenced in it; and transcripts of the witness interviews conducted by the VPD investigator.

[4] The issue on the discipline proceeding is whether the member's performance of the next-of-kin notification fell short of the departmental standard and if so, whether the member's failure to meet the standard was reckless or intentional.

[5] For the reasons that follow, I find that misconduct has been proven.

2. ALLEGATIONS

[6] The allegations arising out of the Section 117 review were as follows:

1. That on June 25, 2019, Constable [redacted] committed discreditable conduct pursuant to section 77(3)(h), by conducting herself in a manner that the member knows, or ought to know, would be likely to bring discredit on the police department, by failing to meet professional standards in the delivery of a next-of-kin notification;

2. That on June 25, 2019, Constable [redacted] committed neglect of duty pursuant to section 77(3)(m)(ii), by failing, without good or sufficient cause, to promptly and diligently prepare for, or review professional standards in relation to, the delivery of a next-of-kin notification;

3. That on June 25, 2019, Constable [redacted] committed discourtesy pursuant to section 77(3)(g), by failing to behave with courtesy due in the

circumstances towards a member of the public, [redacted], in relation to the delivery of a next-of-kin notification; and

4. That on June 25, 2019, Constable [redacted] committed abuse of authority, pursuant to section 77(3)(a), by performing her duties in a manner that tended to demean or show disrespect to a person, [redacted], on the basis of that person's race, colour, or ancestry, or economic and social status.

[7] I will say at this stage that in my view because all four of the allegations pertain to the same transaction on the part of the member, it is fair and appropriate that the misconduct be characterized as one allegation of neglect of duty; the most applicable type of misconduct under the *Act*. This will be discussed in further detail in Part 4.

3. RELEVANT FACTS

[8] The proceedings at this point are not public and names will be redacted if the decision is posted or disseminated outside the statutory participants. In order to reduce the number of redactions I shall refer to the participants in descriptive terms rather than by name, wherever possible.

[9] The complainant's [redacted] son, [redacted], left home on [redacted] and failed to return. The complainant filed a missing person's report with the Missing Persons Unit [MPU] of the Vancouver Police Department. Tragically, her son was found some days later, deceased [redacted]

[10] The member and her partner, who had been uninvolved in the investigation to that point, were assigned to provide the next-of-kin notification to the complainant. They attended her residence on June 25, 2019 with a Victim Services worker. The officers waited for the worker outside the residence for a time, during which the member obtained information about the circumstances of the death and the missing persons complaint.

[11] The complainant, [redacted] and [redacted] were at the residence when the officers arrived. They had seen the officers waiting outside, and anticipated bad news.

[12] The member entered the apartment, stood at the entry hallway with her hands on or near her belt, and stated, "First of all, [redacted] is dead." She did not preface her statement in any way or invite the complainant to be seated.

[13] The complainant buckled, and [redacted] caught her. After she composed herself, the complainant told the member that she needed to work on her delivery and that she should watch "Grey's Anatomy" to learn how to do it properly.

[14] The officers left very shortly after that, concluding that the complainant had family support and did not want them to stay. The Victim Services worker provided them with some materials on grieving.

i. Witness Statements

[15] The complainant, [redacted], and [redacted] provided descriptions of the member's delivery and stance, including terms such as disrespectful, tactless, inconsiderate, callous, insensitive, hard core, emotionless; very blunt, compassionless; and "checking a box". The complainant questioned whether the member would have behaved the same way toward a non-Indigenous next of kin "in West Vancouver", or if her son had not died in the downtown east side. She contrasted the member's approach with the MPU personnel she had dealt with, who she described as consistently professional, kind, gentle and compassionate.

[16] The incident stood out to the Victim Services worker, who did not know the officers, because, as she described it, the way the member delivered the news was "somewhat insensitive … in relation to her body language"; was "quite a callous" delivery; and was "very abrupt" compared to what she was used to seeing from VPD

officers. She added that the member conveyed no empathy on her face and seemed insensitive, like she wanted to get it done and go.

[17] The worker was aware that officers need to stand with their hands near their gun and she assumed that was what the member was doing. She further described the member as having a "very blank" face, talking "cool and tough guy, kind of," and "just like hard core, intense, almost."

[18] The worker described the apartment as small and "claustrophobic". The occupants and the visitors were all in the hallway. The worker had attended a number of next-of-kin notifications, and in her experience most VPD officers are quite compassionate with their delivery. Some are more skilled than others, she said, but overall there seems to be quite a bit of skill with it. Most officers are mindful of their body language and facial expressions. They generally give the recipients time to process the information, while being direct. Her view was that it should be performed in a way that expresses understanding of the recipient's pain. She had made a note that the complainant had asked to speak with a superior or the officers' sergeant, which indicated to her she may have raised an issue at the time.

ii. The Member

[19] In her interview with the departmental investigator the member stated that she and her partner waited 30 to 40 minutes outside the residence for the worker to arrive, during which time she reviewed the missing persons file and gathered information about the death, discovery, and missing persons report. She indicated that the MPU advised her to have a Victim Services worker present because the complainant was extremely worried and distraught about where her son was.

[20] On entering the suite, the member said, she found the complainant to be "very anxious" and "a little hostile". She and [redacted] came into the hallway, "demanding to know" information from the officers. The member felt very uncomfortable. Based on

her training, she decided the best thing was to tell the truth, so she told her that her son was dead.

[21] The complainant fell to the floor, and after [redacted] consoled her she "lit into" the member "about Grey's Anatomy". After the worker had given the complainant a booklet on grieving, the officers left. It was a short encounter and the member regretted that the complainant felt she was not compassionate enough. There were "so many" people present that she believed it best for them to leave. The complainant did not seem to want them there, or want compassion or help. The member would have stayed longer if the complainant had been alone or seemed overwhelmed, or if her family members were unhelpful. Because there were "4 or 5" people there, the member felt it would be inappropriate to stay longer.

[22] The member did not deny that she had delivered the news as described by the complainant and her family members. She did not recall her specific wording. She reiterated that the complainant was very anxious and came up to her aggressively as if to say, "spit it out, tell me why you are here". While she did not say these words, the member felt tension in the room, and the complainant and [redacted] came close to her as if pressing to know why they were there. The member felt it was important to provide the information. The suite was small, the complainant's family were "sitting in all the seats", and "demanding to know" why they were there. The member said she did not like giving next-of-kin notifications and "no one does".

[23] The member had been a police officer since January 2017,[1] and had a day of next-of-kin training at the Justice Institute, so perhaps two years or so prior to the incident. She recalled that her training had recommended using direct and clear language about the status of someone's loved one and commented that "unfortunately

[1] FIR, p. 23

this verbiage can come off as harsh", but that the training is to be direct and tell someone that their loved one is "dead" or "deceased," to prevent confusion. The member had done one next-of-kin notification prior to this one, and numerous others since. She said every situation was different. She commented that if she was present at the scene of a sudden death she would sometimes take personal belongings to the next of kin. Sometimes she would stay longer to answer questions. This was a very unusual situation because she did not attend the scene of the death, she was only given information by the MPU, and the complainant was "aggressive and confrontational" and had a number of family members with her.

iii. The Member's Partner

[24] The member's partner stated in his interview that they were surprised to find several people in the small apartment, which he described as a confined space with a lot of clutter. The officers and the occupants stood inside the entryway, in a small hallway. He perceived that there was no place where it would be convenient to come in and sit down.

[25] The partner described the member as very direct and to the point. She spoke clearly and did not use any euphemisms. She identified the complainant as the deceased's mother, and said, "[redacted] is dead." He was not taken aback by the delivery. He observed that the complainant was very distraught, as were the other family members. He recalled that the complainant told the member she should watch "Grey's Anatomy" to learn how to deliver this kind of information. It did not appear that the complainant had any interest in speaking further with them, so they promptly left.

[26] As they left the residence he and the member discussed the complainant's reaction and agreed that the delivery was "textbook". The member was direct and to the point, and did not go above and beyond what is expected in a next-of-kin notification. He commented that officers were trained not to fluff it up, hug or offer

physical support or tissues[2]. He noted that even the Victim Services worker said she was fine with the way it was delivered. All three of them agreed it was direct and to the point, and there was no sense that it was offside or inappropriate.

[27] The partner had delivered next-of-kin notifications prior to this one and said his delivery would be similar in this situation, given that the environment was not conducive to a sit-down conversation. He believed the complainant was likely aware of why they were there, as she was already crying when they arrived, and being consoled by her family members. There was no opportunity to sit down or deliver the news in another manner.

[28] In relation to the Justice Institute training, which the partner had taken three years prior, the partner recalled thinking that the delivery was exactly the way they were trained: "textbook;" direct and clear, without euphemisms like "passed away", having a Victim Services worker present, and leaving when the subject declined support. He confirmed that he was aware that the complainant was Indigenous.

iv. Section 132 Investigation

[29] At my request under Section 132, the discipline proceeding was adjourned for the VPD investigator to prepare a further investigation report pertaining to the training and materials relating to next-of-kin notifications that were provided to the member at the Justice Institute of BC ["JIBC"] or contained in VPD policy, and specifically, any reference to a requirement for compassion in the delivery of such notifications.

[30] The investigator noted in his report that he was unable to identify the instructor or to identify the specific training the member would have received at the JIBC. He provided a list and copies of the training materials he was advised by the JIBC would

[2] FIR, p. 27

have been provided to the member in her JIBC course, and provided his report pertaining to these supplementary materials. The following is a summary of the materials that were identified in the supplementary report as having been provided to the member during her training at the JIBC in relation to death notifications.

a. Death Notification Pocket Guide

[31] The first of the materials provided by the JIBC is entitled, "Death Notification Pocket Guide," a two-page pamphlet which has the appearance of something that could be conveniently reproduced for placement in a patrol notebook. The text of it is reproduced here in entirety, at about 250% magnification of the version provided by the investigator:

DEATH NOTIFICATION POCKET GUIDE

The manner in which a death notification is delivered can have a positive or negative impact on what may be an already delicate situation.

While delivering a death notification can be an extremely stressful experience, there are ways to ensure the notification is provided with clarity and compassion.

When delivering a death notification, it is critical to be well informed and prepared, as next of kin deserve accurate and complete information about the death of their loved one.

PLANNING

- Notification should be made as soon as possible
- Identify and verify legal next-of-kin to be notified (spouse, parent, legal guardian, etc.)
- Verify victim's full name, age (if known), and relationship with the family members being notified
- Know all the details available surrounding the death of the victim
- Know the location of the victim and the process for family members to see the victim and/or make arrangements to recover their loved one
- Familiarize yourself with local victim services:

NOTIFICATION

- Introduce yourself
- Confirm identity of person with whom you are speaking and their relationship to the victim
- Ask to come inside and ask/encourage family member to sit down
- Provide a one sentence statement to prepare the family for the news (i.e. "I'm sorry to have to share this news")
- Provide notification immediately following preparation statement, using the victim's name and clearly understood words such as died, death, or dead.

  Example notification: "I'm sorry to inform you that your son David died this evening as a result of a traffic accident"
- Provide family member(s) details of when, where, and how death occurred
- Provide family member(s) with current location of the victim and the process to make arrangements to see and/or recover the victim
- Advise family member(s) of Coroner's contact information

AFTER THE NOTIFICATION

- Be prepared to repeat information to both the next-of-kin and family members
- Be prepared for any type of emotional or physical reaction including denial, anger, screaming, fainting, vomiting, etc.
- Do not leave family member alone. Ask if you can call anyone for them and wait until that person(s) arrives
- Provide family member(s) with contact information for Victims Services for assistance with emotional support, funeral information, grief counselling, 24 hr. crisis line, etc.

b. Sudden Death: Out of Area NOK Notification and Reporting

[32] The second document produced by the investigator in the supplementary report is entitled, "Sudden Death: Out of Area NOK Notification and Reporting," which the investigator described as follows:

> This is a document that describes a scenario based training exercise where recruits are asked to deliver a next-of-kin notification that originates from an outside jurisdiction. It states one of the scenario objectives is demonstrating communication skills and empathy during a next-of-kin notification.

[33] On review, the document appears to be a preparation sheet for a role-playing exercise by recruits. It states at the outset:

> Through this scenario, the recruit will:
>
> - Demonstrate communication skills and empathy during [a next-of-kin] notification.

[34] In the portion of the document describing how the evaluator is to provide feedback to the recruits, it contains a list of 11 criteria, which include the following items as second, fourth and fifth on the list, respectively:

- Demonstrating tact when making first contact
- Attempting to get [the recipient] seated/comfortable prior to notification
- Demonstrating sensitivity and empathy when giving notification

c. Recruit Manual

[35] The third document the investigator identified as included in the materials provided to recruits by the JIBC is an excerpt from the Investigation & Patrol Block I Recruit Manual, Chapter 8, entitled, "Sudden Death Investigations". This excerpt includes a section headed, "Notify Next of Kin of Death," which states:

> You will have identified the deceased's next of kin as part of your investigation. When the next of kin lives in, or close to, the municipality served by your department, you will notify the next of kin in person.
>
> If you are unable to attend and notify the next of kin in person, you will obtain the assistance of the police jurisdiction in which the next of kin resides.

[36] The rest of the excerpt deals generally with duties relating to investigation of sudden deaths. It concludes with the following:

> These lists are not exhaustive. Make sure to follow your department's policies for conducting and reporting on sudden death investigations.

[37] The VPD Regulations and Procedures Manual chapter on sudden death investigations is discussed in section v. below.

d. Victims of Crime Committee Letter

[38] The last item in the package the investigator identified as having been provided to recruits at the JIBC is a letter authored by the Canadian Association of Chiefs of Police Victims of Crime Committee. The first portion of this letter reads as follows:

> **July 14, 2016**
>
> **Second Release**
>
> **re: Death Notification**
>
> The Canadian Association of Chiefs of Police Victims of Crime Committee's mission is to enhance the Canadian Police community's capacity to respond effectively to the needs of victims of crime. Among its goals and objectives, the Committee aims to give a voice to victims by listening and working collaboratively to advocate for change and to promote effective practices that address their needs.
>
> Victims and their families have raised concerns with the way in which police agencies across Canada perform death notifications. As such, Committee member agencies undertook reviews and research of existing death notification policies, practices and training. Based on this research and the recommendations from victims and their families, it was identified that there was a strong need for some basic standardization regarding death notification across Canada. The Committee believes that all law enforcement agencies should be assured that if they request that another agency performs a death notification on their behalf that they would do so using the same process.
>
> Every death notification has a long lasting impact on family members. Victims and their families have told us that the manner in which a death notification is delivered can have a positive or negative impact on what may be an already delicate situation. While delivering a death notification can be an extremely stressful experience, there are methods to ensure the notification is provided with clarity and compassion.

> When delivering a death notification, it is critical to be well informed and prepared, as next-of-kin deserve accurate and complete information about the death of their loved one. To assist in performing a death notification, the Victims of Crime Committee would like to share the attached Death Notification Pocket Guide as a best practice. The pocket guide, based on the pocket guide used by Calgary Police Service, is a useful reference tool that law enforcement agency members can refer back to when performing a death notification…

[39] The letter goes on to describe the Pocket Guide, and then adds a reference to a video entitled, "A Knock at the Door," which the letter recommends as a supplement to departmental training on death notifications. The letter states that the video breaks down the process of performing a death notification and reinforces the need to ensure all death notifications are conducted with dignity, professionalism, and compassion. It also states that the Victims of Crime committee believes that the Pocket Guide and video will assist law enforcement agencies across Canada in providing a victim-centered approach to death notification which focuses on respect and dignity to the victim and family.

[40] The investigator was not able to confirm whether the video was shown to the member as part of her training at the JIBC, although the copy of the letter included in his report contains a URL address and link to the video.

v. VPD Regulations and Procedures Manual, 1.6.38

[41] In addition to the materials included in the supplementary report, the final investigation report in this matter included a section of the VPD Regulations and Procedures Manual ("RPM"), 1.6.38, paragraphs 24 to 34 of which pertain to Next-of-Kin Notifications. These sections emphasize the need for in-person notification and timeliness but do not contain detail as to the content or manner of delivery.

[42] The following passages are from this part of the RPM:

> **POLICY**
>
> …
>
> 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.
>
> **PROCEDURE**
>
> …
>
> **Next-of-Kin Notification**
>
> 24. 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.

4. ANALYSIS

[43] As earlier stated, the issue at a discipline proceeding is whether the alleged misconduct is established by the evidence on a balance of probabilities. For most types of misconduct, this entails a consideration of the reasonableness of a member's conduct, from an objective standard, and also from a subject viewpoint based on the circumstances as perceived by the member. Many types of misconduct employ a standard of intention or recklessness in relation to the member's mindset, with the basic premise that something more than inadvertence or negligence is generally required to support a finding of misconduct.

[44] For these purposes, I am prepared to assume that for any of the allegations set out above, the subjective question is whether the member was reckless as to whether her conduct met the applicable standard. The first question of course is, what was the standard?

[45] Member's counsel, Mr. [redacted] filed written submissions which I will refer to as I proceed through the analysis. I agree with him that the initial question is whether there is a duty or departmental standard requiring compassion as a component of the delivery of a next-of-kin notification. If the answer to that question is no, that is the end of the matter. If it is yes, the question becomes whether the member recklessly failed to adhere to the standard, when viewed from the standpoint of a similarly experienced officer standing in her shoes.

[46] One related issue that often arises in relation to an officer's mindset is whether the standard that applied was the subject of adequate training by the department. Case law has suggested that if there is a deficiency in conveying the applicable standard to recruits, in the academy or in the field, that might support a finding of good faith (or lack of recklessness) on the part of the officer: *Lowe v. Diebolt*, 2013 BCSC 1092, at para. 52; *Scott v. British Columbia (The Commissioner)*, 2016 BCSC 1970.

[47] In relation to whether there is a duty or standard of compassion for death notifications as a matter of departmental policy or practice, member's counsel submits that the term "standards" in the context of policing and police training has a very precise legal meaning. The existence of a "standard" creates a duty in those who have been trained in the standard, failure to comply with which may lead to a finding of professional misconduct. Police standards can be established by general law (e.g., standards for arrest or search), departmental policies or standards, or provincial standards, but there is no legal "standard of compassion" either in the general law, or under the Police Act.

[48] Counsel further submits that the member did not understand her training to impose a standard of compassion; no evidence of a standard of that type was provided in the final investigation report; and, while the training materials contained in the supplemental report recommended compassion and empathy, they did not contain

specific direction as to how to fulfill those criteria. He submits that there is accordingly no identified standard in terms of the manner of delivery to which a member may be held.

i. Departmental Standard

[49] In relation to what the evidence shows as a departmental standard for delivery of next-of-kin notifications, I make the following observations. Of the four documents that the investigator established were provided to recruits at the JIBC, three of those place the element of compassion in a prominent position in the list of criteria for delivery of a next-of-kin notification. The fourth, the Recruit Manual excerpt, does not contain any guidelines as to the manner of delivery, deferring to departmental practice. Similarly to the VPD RPM Section 1.6.38, the Recruit Manual outlines procedures and steps to be undertaken during a sudden death investigation, one step of which is the next-of-kin notification. The brief direction in relation to that aspect speaks about timing and logistics. Notably, in the VPD RPM, the relevant section is prefaced with the requirement for compassion and sensitivity in all steps.

[50] To the extent that these sections of the respective manuals do not outline the components of a death notification, they appear to defer to departmental or other materials, or perhaps to presume that the term “next-of-kin” notification will be sufficient to import any supplementary training, materials, or departmental policies, much as the terms “search,” “document,” or “report” used in these sections might also do. Certainly, neither manual is inconsistent with the other materials promoting compassion as a prominent component of a death notification, nor does either endorse any lesser level of empathy.

[51] Apart from the manual excerpts, the materials identified on the Section 132 investigation, which the evidence establishes were provided to the member as a recruit at the academy, clearly outline the potential negative or positive impact of the delivery

of news of a sudden death to a loved one. The fact that a day-long course is dedicated to the topic for recruits, that the materials provided within it appear to consistently emphasize the requirements of compassion and empathy, and that there appears to be a role-playing exercise that entails an assessment of those components, among others, all support a conclusion that these principles constitute departmental standards. This evidence presented on the discipline proceeding on balance points to a finding that the member was trained to a standard that included the component of compassion in the delivery of a next-of-kin notification.

[52] Certainly, it appears that the VPD RPM could stand some elaboration on the topic, and perhaps the Pocket Guide and VOCC Letter should be imported into it, if they have not been by now. However, as I have observed, the Pocket Guide appears to have been designed as a supplement to an officer's notebook, and I am drawn to the conclusion that the member must have left the academy with a binder of materials and a recruit manual that provided her with an ample foundation on which to base her preparation for a call of this nature. Certainly she has not offered evidence to the contrary.

[53] The absence of the death notification materials from the VPD RPM also does not detract from a conclusion that the Pocket Guide and VOCC Letter represent a provincial, or at least a Lower Mainland pan-departmental expectation that these duties will be discharged in a way which prioritizes empathy and compassion.

[54] It is implied, as well, in the VPD RPM, by the suggestion that in-person contact is a priority, that a "personal touch" is one of the manual requirements, or at very least, that the delivery should not be in an impersonal format such as by telephone. This is consistent with a standard of compassion, or at very least not inconsistent with it. The recommendation in the excerpt from the JIBC manual that a member comply with their own departmental policies, given that this excerpt accompanies the other materials,

supports a conclusion that the standard of compassion conveyed in those materials was the "departmental policy" being taught to the recruits, at the same time.

[55] I do note that the VPD RPM, which is available online in entirety[3], oddly contains only three references to the word "compassion" within its 748 pages. The first is on page 150 of the manual, in Part 1.6.25 Missing Person/Child, under the heading, "Policy":

> The principles of respect, compassion and empathy must guide all missing person investigations.

[56] The second reference to compassion is on page 454 in Part 1.14, Community, Diversity, and Victim Services, 1.14.4, Initial Contact with Transgendered People, under the heading, "Policy":

> Part of the core values of the VPD are compassion and respect.

[57] The third and final reference to compassion in the manual is on page 584, in the section on Information Management, under the definition of "Inappropriate material," the last sentence of which states:

> When determining what constitutes inappropriate material, Personnel Services staff shall be guided by our organizational values of integrity, compassion, accountability, respect, and excellence.

[3] https://vpd.ca/policies-strategies/vpd-regulations-procedures-manual/

[58] Reference to these as "core" and "organizational" values prompted me to review the VPD website, and observe that the page entitled, "About the VPD" states as follows:

> **Our values**
>
> In addition to the ***Police Act***, our **Provincial Policing Standards**, and our internal policies and procedures, our five ICARE core values guide us in everything we do.
>
> - Integrity
> - Compassion
> - Accountability
> - Respect
> - Excellence

[59] Lest I be faulted for exceeding jurisdiction by conducting an internet search, I hasten to add that my intent in researching the VPD core values is not to supplement the record provided by the investigator and the materials in this matter; rather simply to follow up on a statement about "organizational values" contained in the VPD RPM, a section of which was filed as part of the record.

[60] In any event, whether or not the VPD website stands as evidence in this particular matter, the inclusion of that attribute as one of the core values of the department does not assist the member in an argument that it is not a recognized standard in an assignment of this nature, dealing with a bereaved member of the public receiving the worst possible news.

[61] Even without that observation, in this matter, the materials amply support a finding that the element of compassion is a prominent feature in the death notification training materials for new recruits at the JIBC. I am satisfied that the examples provided in the role-playing exercise and the guidelines included in the Pocket Guide represent the standard for delivering this kind of life-altering news. Those materials make it clear that this is a solemn duty that can create either a negative or positive impact. The

departmental policy contained in the VPD RPM is neither inconsistent with that, nor does it support any lower standard.

[62] Based on the available materials in this matter, in my view, considered objectively, the argument that there is "no standard" of compassion in departmental policy pertaining to interactions with members of the public in the delivery of death notifications is not supportable.

ii. Adherence to the Standard by the Member

[63] Turning to the member's manner of delivery in this matter, objectively considered, it fell short of the standard, in my view. This finding is supported by the observations of all present except the member's partner, and even the fact that the partner discussed it with her afterward suggests that it stood out to him, albeit perhaps mainly based on the complainant's reaction. In addition, I note the inconsistencies in his and the member's evidence as compared with the other witnesses, pertaining to the number of occupants in the apartment and/or the lack of available seating, which I will discuss below in relation to the member's subjective mindset. At this point I will observe that the partner's evidence, including the observation that the member's delivery was "textbook," suggests an inclination to support the member's version of the events, or at least perhaps a less than objective viewpoint.

[64] I consider the most objective account to come from the Victim Services worker. The member's manner of delivering the death notification clearly stood out to her as "callous," in comparison to what she had seen from other members of the same department. The worker's use of words such as "insensitive", "abrupt", "callous," "tough," and "hard core," and her comparison with other officers she had seen all support a finding that the member's delivery departed markedly from the departmental standard, from an objective standpoint.

[65] In terms of elements contained in the materials that could have been included in the notification but were not, I note that the complainant was not invited to sit down, nor asked whether there was a place they could sit or speak privately. The message was not prefaced with any kind of introduction, expression of sympathy, or statement that could help the complainant prepare for the news; not even the simplest "I'm sorry." The member's body language as described by those present was hard, and her face was expressionless.

[66] Objectively considered, I accept the descriptions contained in the witnesses' statements, with the exception of the partner, and that those descriptions establish that the delivery fell short of the standard expected by the public and, as I have found, that prescribed by the department, in relation to such matters.

iii. Subjective Mindset of the Member

[67] As noted earlier, if I find there is an objective standard of compassion in relation to the delivery of a next-of-kin notification and that, objectively considered, the member failed to meet it, the next question is whether the member's failure was either intentional or reckless, viewed from the perspective of the officer in the circumstances in which she found herself, but measured against a standard of reasonableness. The questions that arise from the evidence in relation to the member's mindset are whether she was unaware of the standard due to departmental or training deficiencies, or whether the circumstances created a reasonable excuse for abandoning a standard that was known to her.

[68] Member's counsel's submissions in relation to the member's level of training, awareness of the standard, and ability to comply with it, may be summarized as follows. The member had been a police officer for only a year and a half and had done only one prior next-of-kin notification. She recalled being trained to use direct and clear language including the words "dead" or "deceased," to prevent confusion for the next of kin. The

member's partner supported her description of the training to the effect that the delivery should be direct, clear, not use any euphemisms such as "passed away," or "he's gone to a better place," and not "fluff it up, hug, or offer physical support or tissues." Members were trained, he said, to provide information and offer the family Victim Service support, then leave if they decline.

[69] Counsel submitted that the member had no specific departmental training about how to do a death notification; and that the VPD does not offer special training. He said the content of the JIBC training must be considered in light of the expectations and policy of the VPD, which require only that the delivery be conducted "in as timely a manner as possible." He submits that the principal function of the police officer in this situation is to advise family members of the basic fact that the deceased has died, and to provide information the police may have collected about the circumstances of the death. It is the role of a Victim Services counsellor to provide emotional and other support, with the officers, but as members of a team with different roles.

[70] The gist of these submissions is that information about the applicable standard in relation to the manner of delivery of a next-of-kin notification was neither provided to the member during her training, made available to her within departmental policy literature, nor afforded to her in the field during her limited experience.

[71] I will note at this point that again I agree with member's counsel that the conclusions regarding the member's understanding of the applicable standard must be found in the record on the discipline proceeding. I note that the previous absence of materials in support of the member's understanding of the standard (or lack thereof) has now been supplemented with the JIBC materials in the additional report. Notably, those have not been the subject of comment by the member. The question of what the member understood about her duty will therefore need to be resolved based on the evidence provided at the discipline proceeding without the member's own explanation

as to why she did not adhere to what I have found to be the objective standard disclosed by the supplemental materials.

[72] As noted earlier, the evidence establishes that the member received the JIBC materials as a recruit, and participated in a day-long course dealing with death notifications, within about a year and a half before the incident. In addition, it appears evident that the course involved some role playing and commentary regarding recruits' performance of next-of-kin notifications, including their fulfillment of the various criteria, several of which as I have noted focussed on compassion and ways to achieve it. I am unable to find in the evidence any support for a conclusion that the member's training was not typical of that suggested in the materials. I have already commented on the partner's evidence. The absence of an opportunity to assess either witness in viva voce testimony with cross-examination leaves my concerns regarding objectivity unaddressed, and the members' evidence regarding their training in my view falls short of refuting the inferences available from the materials.

[73] I have therefore surmised that the member would have left the academy with the Pocket Guide, the VOCC letter, a "Recruit Manual," and that she would have had the benefit of a role-playing exercise in which her notification delivery was assessed for the listed elements, including compassion and empathy. As I have noted in assessing the member's adherence to the standard, the steps recommended in the exercise include asking the recipient to sit down, and offering a preparatory statement, such as "I am sorry to have to inform you," before providing the news of the death.

[74] As with any other training a member receives, the member must be ascribed with knowledge of the contents of what the materials disclose about her training. If the member was unaware of this training or the contents of the materials, in the absence of testimony explaining a different, reasonable interpretation of them or some reason for

not having received or absorbed them, her lack of knowledge in that respect can only amount to apparent recklessness.

[75] Another body of evidence pertaining to a member's expected level of understanding of the departmental standard might come from the Victim Services worker, who had considerable experience in observing VPD next-of-kin notifications. Her evidence supports a conclusion that most officers in the VPD exhibit a level of compassion appropriate to the circumstances, and appear to be aware of the standard.

[76] What we do not know is whether the member had the opportunity to observe other officers conducting these notifications, apart from the single prior one that she performed. Presumably she had seen others, or if she had not, she could have informed her partner that she did not feel experienced enough to conduct this notification. If the member's experience was somehow deficient in comparison with reasonable departmental expectations, to the point where she had a reasonable excuse for not meeting the standard met by other officers, and/or she did not feel free to decline the assignment, those are factors that are not disclosed by the evidence on the discipline proceeding.

[77] While counsel has noted the deficiency of the VPD RPM in its treatment of the manner of delivery of death notifications, as I have noted, that does not in my view detract from the standard apparently provided in the training. In the absence of a direct assertion that the member understood the manual to somehow negate the standard of compassion contained in her training, I am unable to find support in the evidence for a mindset of good faith or inadvertence based on a lack of training or unavailability of departmental information about the standard.

[78] The apparently blatant omissions of the suggested "preparatory" statements or actions contained in the Pocket Manual and the exercise outline are simply unexplained by direct evidence from the member. In light of the emphasis apparently placed on

these steps in the academy materials, and the inference I have drawn about the materials the member would have taken with her from the academy, the only available conclusion is that the member was reckless as to whether she followed the training and materials she had received.

[79] In relation to whether the member was prevented from carrying out her duty with compassion on this particular occasion, member's counsel submitted that the residence was small; family and friends of the complainant were present and occupied all the seating areas; the deceased had been missing for four days; and having seen the police entering the apartment complex, the complainant and her family members expected bad news. He suggested they were "no doubt in a state of excruciating anxiety". The member said six words, he submitted, none of which were offensive or insulting, individually or collectively, and she did not have an opportunity to say anything more. The situation was uncomfortable for her.

[80] Looking back, he submitted, the member acknowledges that she could have shown more compassion, but at the time she simply followed her training and had no intention of causing additional trauma or grief. She was tasked with being the bearer of the worst possible news – a duty among the hardest of many difficult duties that police officers must carry out. Interpretations of another person's body language are obviously very much subject to error and misunderstanding, counsel submitted. An objective observer could easily see the enormous potential for misperception and misunderstanding.

[81] I will here note again that the evidence of the member and her partner are at odds with that of the family members and the Victim Services worker as to the availability of seats within the residence. It appears from the family members and the worker that there were only three family members present, including the complainant, and all were standing in or near the hallway where the member stood to deliver her

notification. The members indicated that the available seats were “filled” with family members or that the apartment was not conducive to getting the complainant seated before delivering the news. Although the worker agreed the residence was “claustrophobic,” the statements of both members in relation to the unavailability of an opportunity to invite the complainant to be seated appear, with respect, to be overstatements.

[82] I do not accept that the seats were fully occupied; however, even if they were, this would not in my view have provided a lawful excuse for departing from a reasonably compassionate approach to the notification. Even if it appeared to the officers that there was a lack of seating, there was nothing preventing the member from asking if the complainant would like to sit down, or saying something -- anything -- more about the reason for the members’ visit before, essentially, “ripping off the bandage,” as the member admittedly did.

[83] I note that the member also offers the fact that the complainant and family members appeared to want her to “get on with it” as an additional explanation for her direct approach. In my view, this willingness to attribute responsibility to the complainant for the terse delivery of the tragic news only supports a lack of compassion on the part of the member. Counsel’s comments about the likely “excruciating anxiety” of the family members, and the “potential misperception and misunderstanding,” highlight factors that should have informed the member’s approach to the assignment. The member was admittedly aware before she attended that this was a sudden death notification, in the wake of a missing person’s report, and that the complainant was “extremely distraught.”

[84] The complainant’s level of distress therefore cannot have taken the member by surprise or robbed her of an “opportunity to say anything more,” as submitted by her counsel. To the contrary, even an assertive, or indeed, aggressive, query by a clearly

distraught mother should only have elicited a higher level of compassion, or at very least, a preface along the lines of that suggested in the training: “I am sorry to have to inform you…” Ideally, as indicated, that would have followed a query as to whether the complainant would first like to sit down. The complete lack of either is simply not explained by the evidence in a manner that might provide a lawful excuse.

[85] I note that in the section, “After the Notification,” the Pocket Guide suggests all manner of potential physical and emotional responses that an officer might anticipate from the recipient of the news. That section certainly does not suggest that a lower standard of compassion is justified in the face of any such reactions.

[86] I want to be clear that the member is not being faulted for behaving in a less than ideal manner. The only question at this point is whether she recklessly departed from an established standard of basic compassion in her interaction with the complainant. I am nonetheless unable to find support in the evidence for a reasonable excuse for her stark departure from what I have found to be a departmental standard, and about which I have found she must have been aware, based on her training. Again, without direct evidence from the member explaining how her conduct could amount to good faith, the only available conclusion is that she recklessly departed from the departmental standard of compassion in relation to the death notification.

[87] One explanation that has not been advanced is that the member was so nervous that she essentially choked under the pressure, such that all training and indeed, human compassion, flew from her mind. Similarly to the observation above about her feeling a lack of preparation or experience, I do not have evidence to that effect. In any event, I am not sure it would afford an excuse for a patrol officer whose profession entails a daily requirement of remaining calm under pressure.

[88] As I have noted, the allegations in this matter all pertain to one transaction, the death notification. Although four separate ways of portraying the same act of potential misconduct have been identified, in my view the analysis in relation to the officer's level of intent for each is essentially the same. The only remaining question is which of the allegations best captures what I have found to be the member's reckless departure from departmental standards, and whether an entry for more than one of them is warranted. I will review the elements of each separately with that in mind.

iv. Discreditable Conduct

[89] Under Section 77(3)(h), discreditable conduct is "when on or off duty, conducting oneself in a manner that the member knows, or ought to know, would be likely to bring discredit on the municipal police department."

[90] The following passage from *Toy v. Edmonton Police Service*, 2014 ABCA 353, sets out a suggested standard against which to measure discreditable conduct:

> [11] … In sum, the test involves an objective evaluation as would be made by a dispassionate reasonable person fully apprised of the circumstances and with due regard for any applicable rules and regulations (or law) in force and with due regard to good faith considerations where the officer under scrutiny was required to exercise discretion under the circumstances…

[91] Member's counsel submits that there is no basis to find the member's conduct rises to the level of discreditable conduct. He says she approached this task a certain way and it was not received well by the intended recipients.

[92] I have already found that the member recklessly departed from the departmental standard. The remaining question in relation to discreditable conduct is whether she knew or ought to have known that doing so might tend to bring discredit on the department. In considering that question, I am mindful of the use of the term "discretion" in the above passage. To my mind, the exercise of discretion imports either

a decision-making process or a requirement that an officer maintain decorum. In that respect, discreditable conduct arguably entails either that an officer behave in a way that is lacking in discretion, or that the officer make a bad decision when exercising a discretionary duty.

[93] Without narrowing the application of the section unduly, it strikes me as less applicable to the circumstances in this case, which is more akin to inattention to a standard or failure to competently fulfill an assigned duty. While I am of the view that the member's failure to adequately discharge this particular duty did in fact bring discredit on the department, I consider the aspect of whether she knew or ought to have known that discredit to the department would be the result to be an additional layer of intent that may be lacking in relation to the conduct here.

[94] Put another way, although I see the member's failure as neglectful, I do not see it as either an improper exercise of discretion or knowingly behaving in a discreditable fashion.

v. Neglect of Duty

[95] Section 77(3)(m) of the *Police Act* defines the misconduct of neglect of duty as it relates to this matter as, "neglecting, without good or sufficient cause, to … (ii) promptly and diligently do anything that it is one's duty as a member to do."

[96] A recent case of the Ontario Civilian Police Commission[4] approved the following summary of the legal test for neglect of duty:

> [18] … The charge of neglect of duty is a serious charge under the Code of Conduct. To be convicted of this charge, it must be shown that:

[4] Neild v. Ontario Provincial Police, 2018 ONCPC 1 (CanLII), https://canlii.ca/t/hpv6h

> The member was required to perform a duty, and the member failed to perform this duty because of neglect, or did not perform the duty in a prompt and diligent manner.

Once proven, the member, to avoid discipline, must show that:

> [The member] had a lawful excuse for not performing the duty in the prescribed manner.
>
> …It is not an absolute offence…there must be either "wilfulness" or a degree of neglect which would make the matter cross the line from a mere performance consideration to a matter of misconduct".

[97] It is clear that the member had a duty to notify the complainant of her son's death, which she performed, and indeed, performed promptly, but, I have found, in doing so she failed to fulfill the departmental standard of compassion toward the complainant. The issue, in relation to neglect of duty, is whether the member exhibited a disciplinary level of neglect in failing to do so; and if so, whether she had good or sufficient cause. These elements are closely aligned with the analysis I have already undertaken with respect to the member's conduct and subjective mindset, above.

[98] Counsel for the member submits in relation to this allegation that there was no neglect of duty here. While the member could and should have been gentler in her approach, he submits that she believed in good faith that her blunt and straightforward approach was consistent with her training and the direction to prioritize clarity, in the absence of any real explanation of what compassion means in a death notification. He submits that to the member, compassion may have meant being direct and concise, and not prolonging the notification.

[99] I have already found that the materials and the evidence pertaining to the training received by the member afforded her an opportunity to understand the standard of compassion, and provided a set of steps, in an exercise, exemplifying what that might look like in a particular notification. I have indicated that I do not see room in

the evidence on the disciplinary proceeding for a different interpretation by the member of what she was taught, in the absence of direct evidence on that issue.

[100] Considering the evidence that is available, the compelling conclusion is that the member simply failed to fulfill the duty that was outlined to her in her training and in the materials supplied to her. If those materials were not fresh in her mind or accessible to her for some reason, that remains unexplained on the evidence.

[101] One might conclude that having received a "Pocket Guide" of the nature included in the materials, an officer would take some steps to keep it accessible for use should the occasion arise. I am mindful that the occasion did not frequently arise, for the member, and it may not in fact have been something she would be expected to keep "in her pocket." Nonetheless, it appears there was ample material made available to her with respect to the scope of her duty, and for whatever unexplained reason, she neglected it.

[102] As for whether there might be good or sufficient cause for that neglect, I have already observed that there is no basis for a finding that the member's experience was unreasonably deficient, and I do not accept that the actions of the complainant and her family contributed to an inability of the member to fulfill her duty of compassion.

[103] I note the member's observation in her interview with the investigator that the complainant didn't know her, and that the MPU "sent a random officer to go tell her this information." While I would like to believe she was attempting to convey sympathy for the complainant in making this remark, she said it in the context of assigning responsibility to the complainant for her abrupt delivery of the news. Considered in that context, the "random officer" observation might suggest that the member considered this assignment an imposition; something randomly or inappropriately assigned, and that she may have carried that attitude through to her preparation, or lack thereof, and to her subsequent delivery of the news. This aspect of the evidence points toward a

more intentional neglect of duty and a predisposition to get the task done without the level of preparation prescribed by the training materials, because the member was of a view that it was not reasonably assigned to her. That would elevate the intent beyond recklessness if it were the case.

[104] My view at this stage, in any event, is that the allegation of neglect of duty aptly captures the misconduct exhibited in this matter, including the absence of good and sufficient cause.

vi. Discourtesy

[105] Section 77(3)(g) defines as misconduct, "failing to behave with courtesy due in the circumstances towards a member of the public in the performance of duties as a member." Relevant case law establishes that mere discourtesy is not misconduct. It must be considered whether the officer adhered to the level of courtesy "due in the circumstances," which clearly imports an element of intent and admits of lawful excuse arising from the circumstances in which an officer may find themselves.

[106] The complainant's point as it relates to discourtesy is that the member's death notification was rude and disrespectful, and she felt it treated her as if she was not human. The complainant drew an inference that this was due to racial discrimination, or profiling based on her son's apparent circumstances, which gave rise to a separate allegation of abuse of authority, discussed below.

[107] In relation to the issue of whether the member failed to meet a standard of courtesy that was due in the circumstances, clearly the complainant took offense at the callous delivery, but the initial question is whether the conduct of the officer was objectively "discourteous".

[108] Member's counsel submits that in order to constitute a disciplinary default, discourtesy must amount to abuse of authority. He points to the wording of paragraph

77(3)(a)(iii) which refers to profane, abusive, or insulting language. He submits there is no evidence here to suggest that the member was intentionally discourteous or abusive.

[109] Cases dealing with discourtesy by police officers or other service providers tend to focus on inappropriate language or overt abusive or disrespectful language or treatment. The case law establishes that the standard of care in relation to vulnerable people is higher than that in relation to the general public, or perhaps, that a higher level of courtesy is required for vulnerable people.

[110] While the complainant in this matter was clearly known to the member as a vulnerable person; a bereaved mother; and I have found that she was clearly due the courtesy of compassion as a matter of duty, in my view the failure to fulfill that duty is better captured as a neglect of duty than as an overt act of discourtesy, such as in other cases dealing with this type of misconduct.

[111] In this respect, I agree with member's counsel that it is not as much what was said by the member, but what was not said. To my mind, her deficient delivery of the notification is more aptly characterized as a neglect of duty than as overt discourtesy.

[112] I will add that I do not see evidence here that the member meant to offend the complainant through the manner in which she delivered the tragic news of her son's death. She just utterly failed to adequately prepare the complainant for the news she was about to receive.

vii. Abuse of Authority

[113] Abuse of authority under Section 77(3)(a) imports a requirement of "oppressive conduct". Section 77(3)(a)(iii) defines abuse of authority as follows:

> (iii) when on duty, or off duty but in uniform, using profane, abusive or insulting language to any person including, without limitation, language that tends to demean or show disrespect to the person on the basis of that person's race,

> colour, ancestry, place of origin, political belief, religion, marital status, family status, physical or mental disability, sex, sexual orientation, age or economic and social status.

[114] When one is considering specific language under the second part of the section, my view is that the officer must know or be reckless as to whether the language would tend to be demeaning or show disrespect. In addition, if the alleged misconduct relates to showing disrespect "on the basis of" one of the listed traits, the officer arguably must be aware of or ought to have been aware of that trait, and of the potential effect of the words in relation to it.

[115] While I am of the view that non-language-based abusive or insulting behaviour which tends to demean or show disrespect to a person on the basis of a listed trait such as race, colour, or ancestry, or economic and social status, can be caught by the general wording in subsection (3)(a), the question in relation to the death notification here is whether the member's conduct tended to demean or disrespect the complainant on any of those listed bases, and whether the member knew or was reckless as to that effect.

[116] The member's use of terse words and cold or hard body language clearly fell short of the standard of compassion, but under this type of misconduct, the issue is whether it also constituted the kind insulting behaviour listed in the section.

[117] In this respect, I observe that the complainant and her family members immediately perceived the member's conduct as demeaning and disrespectful. In addition, the complainant believed that the member's conduct was attributable to the complainant's race, colour, and/or ancestry and to her son's economic and social status. Added to that, the member knew of the complainant's Indigenous status and knew that her son had died in circumstances that might suggest a certain social and economic status.

[118] The fact that the complainant considered this to be an example of inequity in treatment at the hands of the police is itself tragic, and points toward a need for greater training in equity, diversity, and inclusion, although I am quite certain that there has been a greater emphasis on that within law enforcement and the legal profession in the several years since this incident.

[119] My personal view is that member should have had access to information about the death-notification recipient's heritage, at least to the effect that it could have provided a trauma or equity-informed background against which to formulate an individualized approach to this kind of sensitive assignment. However, I do not have evidence to the effect that this was the departmental standard in operation at the time of this incident.

[120] The member did not apparently have access to information pertaining to the complainant's Indigenous heritage or ancestry. There is also no evidence to support a conclusion that the member was aware of the need for a different approach in relation to death notifications as they pertain to Indigenous persons, or to the complainant in particular, in light of her heritage. One can envision a world in which individualized plans are made accessible to officers assigned to these life-altering tasks, but the record here does not establish any such standard at that time.

[121] I will observe that there is copious material documenting the likelihood of intergenerational trauma, in this province and the country, for Indigenous persons, and I would be most surprised if this was not a factor well-known to VPD officers. While one must be careful not to assume trauma based simply on information as to a person's Indigenous status, the fact of the complainant's Indigenous status, and the circumstances of her son's death, would in my view at very least have underscored the need for greater, not less, compassion. These are factors for consideration in relation to

the seriousness of the misconduct, but they are unlikely, in my view, to provide a foundation for a finding of abusive conduct attributable to heritage or social status.

[122] I therefore do not believe the evidence supports a conclusion that the member's callous delivery in this matter was consciously or recklessly related to the complainant's heritage or her son's social status. While I remain concerned about an apparent lack of consideration of their background, or of how a next-of-kin notification might best be delivered to a person in the complainant's circumstances, my view in light of all the evidence at this point is that the allegation of abuse of process is not made out, and the allegation of neglect of duty best captures the member's misconduct.

[123] As noted, these surrounding circumstances will otherwise be relevant to the issue of disciplinary or corrective action.

5. CONCLUSION AND NEXT STEPS

[124] I find that the misconduct of neglect of duty in relation to the second allegation has been proven on the evidence at the discipline proceeding. Sections 125(1)(d) and 125(2) provide that the member may make submissions as to appropriate disciplinary or corrective measures within 10 business days of receipt of the Form 3 that accompanies these reasons, or by December 11, 2023. I note that the complainant has previously provided her submissions pursuant to Section 113 of the Act.

[125] This matter will convene for a case management conference on November 27 at 8:45 a.m.

DATED this 27th day of November, 2023.

Carol Baird Ellan, Ret'd PCJ, Discipline Authority