SAANICH POLICE DEPARTMENT
PROFESSIONAL STANDARDS
AUDITS AND PLANS

INVESTIGATION REPORT

PSO FILE 2011-01
(OPCC FILE 2011-6009)

REVIEW OF POLICE RESPONSE
RE: SUICIDE OF 22(1)
(JACK LEDGER HOUSE – DECEMBER 19, 2010)
SAANICH POLICE FILE 2010-30466

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SUBMITTED: FEBRUARY 9, 2011
TO: CHIEF CONSTABLE MIKE CHADWICK #307
SAANICH POLICE DEPARTMENT
DISCIPLINE AUTHORITY

AND TO: THE OFFICE OF THE POLICE COMPLAINT COMMISSIONER

SAANICH POLICE DEPARTMENT

Professional Standards Office Investigation Report

FILE REVIEW | **No Respondent Members Identified** | **PSO # 2011-01**

(COMPLAINANT) | (MEMBER) | **FILE # 10-30466**

Investigator S/Sgt. Kelly Dukeshire #97

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The subject of this report is a Professional Standards Office review and assessment of the police response to the service call received by the Saanich Police Department on December 19, 2010 from Jack Ledger House reporting 22(1) disappearance and subsequent suicide. This review did not stem from any allegation of wrong-doing or suspected misconduct on the part of any employee or officer of the department, nor did it arise from any suggestion that the department's policies or operating procedures were deficient in any way. Rather, the review was initiated due to the tragic circumstances of 22(1) death, in the interests of transparency and in the spirit of section 89 of the Police Act relating to the reporting of death to the Office of the Police Complaint Commissioner in any case where the circumstances *"could be seen to be the result of the conduct of any member of the municipal police department or the operations of that police department".*

Background:

Jack Ledger House is a special care facility that provides housing and treatment for youth who struggle with a variety of mental health issues including suicidal tendencies. Patients are admitted on a voluntary or involuntary basis which impacts their level of independence and ability to move about the buildings and grounds either freely or with limitations and often direct supervision.

Regarding 22(1) at the time of her death she was sixteen years old 22(1)

She was admitted to Ledger House in October 2010 22(1)

On December 19, 2010, moments after being returned to Ledger House following a weekend leave from the facility with her family, 22(1) slipped away from staff supervision and

committed suicide by hanging herself from a tree on a beach area near the grounds of Ledger House. She was discovered by her father who had returned to the grounds to assist with the search.

The Saanich Police Department was notified of 22(1) disappearance at 1736 hrs (approximately 35-45 minutes after she was noticed missing) however, an officer was not dispatched to attend until 1910 hrs immediately following reports of 22(1) discovery. The delayed response was a result of the convergence of a number of unfortunate events including, but not limited to, a strain on the available resources due to a serious but unrelated investigation ('Stabbing/Attempt Murder', file 10-30455 refers), the dynamics of shift change, the management of available units and other incoming calls for service, the prioritization of the missing person call and also the manner in which the call was reported by Ledger House (seemingly routine in nature with little or no sense of urgency).

Outcome of Review:

This review, as detailed in the following pages, has found no causal link or any other connection involving the actions of any employee or officer of the Saanich Police Department which could be seen as a contributing factor to 22(1) suicide. Nor has any nexus been identified between the operations of the Saanich Police Department and 22(1) death. This review has however, resulted in several recommendations aimed at improving existing policies and procedures relating to the department's handling of reports of missing persons.

Note: The following 'Investigation Details' section (pgs. 5-32) contains the facts as discovered during this review. The 'Analysis/Conclusion/Recommendation' section (pgs. 33-46) provides S/Sgt. Dukeshire's analysis of the facts which has led to ten recommendations that are highlighted in 'blue' on those pages.

INVESTIGATION DETAILS

All investigative steps undertaken during the course of this review are not included in this report. The following pages under 'Investigation Details' are intended to represent a condensed overview of the salient topics/facts as learned by S/Sgt. Dukeshire during a detailed review of various sources of information which included the following:

1. The Saanich Police investigation/PRIME reports under file 10-30466 which contained,
    a. Transcripts and summaries of interviews with Jack Ledger staff and physicians,
    b. Transcripts and summaries of interviews with family members of the deceased,
    c. Narratives from investigating Detectives, attending patrol members and Forensic Identification officers,
2. Interviews with Telecoms staff,
3. Contact with the attending Coroner, Mr. Michael Butler,
4. SPD policies and Operational Manuals (including the Call Taker Manual),
5. Ledger House reporting protocols,
6. Call taker and dispatch recordings, and
7. Other related evidence such as,
    a. Deployment records,
    b. Statements received from various witness officers,
    c. Past calls for service to Jack Ledger House (between 2007 and 2010), and
    d. Telecoms 'bulletins' and 'directives'.

2011 Jan 06

(date of review and applicable case note)

Synopsis (as summarized from the PRIME file 10-30466):

- The incident occurred December 19, 2010.
- The Saanich Police were first contacted at 1736 hrs by Ledger House – *"missing person"* report.
- Deceased - 22(1) (16 yrs).
- 22(1) was on a *"weekend pass"* from Jack Ledger House with her parents. They had travelled to 22(1) and 22(1) was being returned to Ledger House.
- 22(1) had *"spent the previous night at* 22(1) *after disclosing she was feeling suicidal"*.
- 22(1) was located by her father, 22(1) on a nearby beach area where she was found *"hanging from a tree"* near the grounds of Queen Alexander Hospital where the Ledger House is located.

2011 Jan 12

Chronology of Events (Review of 10-30466):

S/Sgt. Dukeshire completed a review of the 120 page PRIME file which included the related CAD recorded events and times. The following represents a chronological summary/timeline of that report:

October 28, 2010:

- 22(1) was admitted to Jack Ledger House 22(1)

22(1)

December 16, 2010:

- The 22(1) family had a meeting with Ledger House staff regarding 22(1) scheduled release on Dec. 17/10. 22(1)
- 22(1) scheduled release was rescinded in order to arrange a suitable alternate living arrangement.
- 22(1) was released to her parents for the weekend with her return expected on Sunday, Dec. 19/10.

December 17, 2010:

- 22(1)

December 18, 2010:

- 22(1) arranged a sleep over with her close friend, 22(1) with the approval of 22(1) parents.
- 22(1)
- During her stay with 22(1) 22(1) became anxious and at approx. 1130 hrs walked to the 22(1) with 22(1) where she was admitted overnight for observation due to feeling *"unsafe"* with her thoughts.
- 22(1) Hospital did not inform 22(1) parents of her admission until the

following morning (Dec. 19/10) at approx. 1030 hrs.

- It appears that the 22(1) family also did not notify 22(1) parents of her admission to hospital (it was approx. 0300 hrs when 22(1) left 22(1) in the hospital's care).

December 19, 2010:

- 22(1) was released from the hospital to the care of her parents.
- 22(1) Hospital contacted Jack Ledger House and informed them of the circumstances of 22(1) admission. The information provided was as follows:
  - 22(1) was admitted at *"midnight"*.
  - 22(1) was with a friend known as 22(1)
  - 22(1) was *"intoxicated making comments of suicide"*.
  - 22(1) Hospital staff believed 22(1) comments to be *"mild in nature"*.
  - 22(1) was *"held overnight for observations"*.
  - 22(1) was not happy that the hospital had called her mom.
  - 22(1) told the hospital staff that *"she was going to commit suicide once she was released from Jack Ledger in January"*.
  - A hospital nurse (22(1) expressed concerns of 22(1) condition during her return to Victoria and suggested that 22(1) sit in a rear seat with someone who could supervise her closely *"to ensure*

that she does not attempt to jump out of the vehicle".

- The hospital advised of medications provided to 22(1)
- The hospital advised Ledger House that they would inform them of the time of 22(1) release (the hospital did not call as promised and a worker from Ledger House contacted the hospital at 1400 hrs and learned that she had been released at *"noon"*).
- The above information was noted in the Ledger House log relating to 22(1) by Ledger employee, 22(1)

December 19, 2010: (continued - pertaining to 22(1) arrival at Jack Ledger House):

1630 hrs (approx.):

- 22(1) arrived at Ledger House.

1645 hrs (approx.):

- 22(1) parents departed leaving 22(1) in the care of Ledger House staff (22(1)).

1700 hrs (approx.):

- After changing into *"hospital pants"* 22(1) and 22(1) went to the *"kitchen area"* where they prepared some tea and set a table at which time 22(1) went missing 22(1) had briefly assisted some other youths and when she looked back for 22(1) she was gone).
- 22(1) informed fellow employee, 22(1) of 22(1) disappearance. Together they began a preliminary search of the

building and of the grounds.

- At some point during this search, 22(1) informed the *"nurse in charge"*, 22(1) that 22(1) whereabouts were unknown. 22(1) and 22(1) continued their search.

1733 hrs:

- 22(1) notified the on-duty physician, the regular physician (22(1) - 22(1) psychiatrist) and 22(1) parents by telephone (the 22(1) were en route home to 22(1) and received the call somewhere near Ladysmith or Nanaimo. They immediately turned around and headed back toward Victoria).

Report of Missing Person – 22(1)

1736 hrs:

- 22(1) telephoned the Saanich Police (SPD) and reported the following (information obtained from a review of the call recording):
  - 22(1) had last been seen approx. 45 minutes prior to her call.
  - 22(1) was not a *"certified"* patient.
  - 22(1) was *"at risk of hurting herself"*.
  - 22(1) had *"presented herself"* to the 22(1) Hospital the previous evening for having *"suicidal ideations"*.
  - Upon 22(1) return to Ledger House the staff observed her to be *"unstable on her feet"*.

- 22(1) provided a clothing description and additional information regarding 22(1) unfamiliarity with the Greater Victoria area.
- 22(1) did not specifically request police attendance but asked that the police *"keep an eye out for her"*.

Note: Regarding the above, see **Conclusion 9** for further comment and analysis.

- The call taker (CT) was CT 1 (PIN CT 1).
- The call was prioritized as *"3"* and placed into the 'regular dispatch queue'. CT CT 1 informed 22(1) of the following:
  - *"We're actually going to have someone, a member, come by and speak with you"*.
  - *"We just have a incident that we're dealing with so it might be a little bit"*. 22(1) responded by saying *"No problem"*.
  - CT CT 1 assured 22(1) that the information pertaining to 22(1) *"will be out there"* (which S/Sgt. Dukeshire interprets to mean it will be made known to members via their Mobile Data Terminals, MDT, by Computer Aided Dispatch, CAD).
- CT CT 1 also added eleven (11) *"call remarks"* to the CAD file (which was viewable by all officers who were signed on to their MDTs). The 'remarks' included:
  - 22(1) clothing description.
  - That she *"was at risk of hurting herself"*.

- Time last seen (45 minutes ago).
- Information regarding her hospital admission - *"last night for suicidal thoughts"*.

- The last updated 'call remark' was posted at 1750 hrs and the call remained in the queue.

1814-1831 hrs:

- 22(1) parents arrived back at Ledger House. Soon after their arrival, 22(1) left Ledger House and began searching personally for his daughter. It appears 22(1) immediately *"ran"* toward the beach where he believed 22(1) would have gone.

Note 1:

22(1) stated in his interview with Sgt. Reid that when he had located his daughter he telephoned Ledger house (250-519-6727 at 1831 hours - time obtained by phone record) yet it wasn't until 1908 that Telecoms received the 911 call for PAS (Provincial Ambulance Service). By 22(1) phone records, his next calls were not made until 1905 hrs at which time Sgt. Reid's report stated he made *"several calls"*, *"in a panic"*. Sgt. Reid's report does not detail '911' calls but it is known from the CAD report that Victoria Police and West Shore RCMP both received 911 calls at or near 1913 hrs and 1915 hrs respectively. 22(1) 22(1) 22(1) Although it is recognized that upon the discovery of his daughter 22(1) would have been under considerable confusion, panic and stress, S/Sgt. Dukeshire questions the accuracy of these times as 30 minutes seems to be an overly excessive time period between the discovery of 22(1) and the first request for PAS (this is not necessarily information relevant to

this Police Act review or the actions of the Saanich Police Department however, it is worthy of note).

Note 2:

On January 17, 2011 S/Sgt. Dukeshire received a phone call from Sgt. Reid who advised she had spoken with the Coroner, Mr. Michael Butler. Mr. Butler informed Sgt. Reid that he had been in contact with 22(1) parents on a regular basis. Mr. Butler stated that during his discussions with them, 22(1) had been adamant that the times he provided to Sgt. Reid regarding his discovery of his daughter were accurate and that 22(1) believes he was with 22(1) for approx. 45 minutes before the first help arrived.

1908 hrs:

- The dispatcher, D 1 D 1, updated the CAD file after monitoring a 911 call for PAS advising that 22(1) *"contacted* (PAS) *stating he found her dead on the beach IFO* (in front of) *2400 Arbutus"* which is the address for the Queen Alexandra Hospital (and Jack Ledger House).

1910 hrs:

- Sgt. Dave Stephens, Cst. Heather Barkley and Cst. Wayne Murdock were dispatched.

1913 hrs:

- Cst. Barkley and Cst. Murdock radioed they were attending *"code 3"* (lights and sirens activated).

- Victoria Police advised Saanich Telecoms that they had also received a

911 call from 22(1) upon the discovery of his daughter.

1915-1919 hrs:

- Saanich Fire Department First Responders arrived on scene.

1917 hrs:

- Cst. Jeff Bevington and his partner, recruit Cst. Lisa Bruschetta were dispatched.

1919 hrs:

- Cst. Barkley and Cst. Murdock arrived on scene (PAS was just ahead of them).

1927 hrs:

- Cst. Bevington and Cst. Bruschetta arrived on scene.

1930 hrs:

- Sgt. Stephens arrived on scene.

Note:

The remaining CAD information involves various transmissions and updates regarding the subsequent police attendance and investigation. No concerns have been identified once 22(1) was discovered. The police response from that point appeared to be immediate, thorough and appropriate.

2011 Jan 13 **Sgt. Makarewich Review (January 4, 2011 Memo)**:

S/Sgt. Dukeshire reviewed Sgt. Makarewich's Jan. 4/11 memo to Insp. Rhodes which detailed her knowledge of events relating to the suicide; S/Sgt. Todd Bryant's memo to Insp. Edwards regarding his actions leading up to shift change; and S/Sgt. Rob Piercy's memo to Insp. Edwards regarding his actions upon commencing his night shift. The following additional information was learned (note: the following information should be considered in combination with the timeline detailed on the previous pages):

- In her memo, Sgt. Makarewich identified all staff working in Telecoms on Dec. 19/10 leading up to and at the time of 22(1) reported disappearance.

- Sgt. Makarewich stated the *"stabbing call"* (10-30455) was received by SPD at approx. 1419 hrs and was considered *"serious"* as the victim was in *"critical condition"* in the hospital.

- Sgt. Makarewich stated the investigation occupied *"all of the dayshift officers and there were no available Saanich Units"* including the traffic members.

1505 hrs:

- S/Sgt. Bryant, recognizing that his units were tied up with the stabbing investigation, inquired with Telecoms as to the calls that were currently in the queue. He was advised that there were no significant calls waiting. S/Sgt. Bryant was advised by A/Sgt. Stuart of the *"seriousness of the call"* and stated *"it was clear that all of our resources were committed to critical duties necessary to preserve and protect the scene and maintain the integrity of the investigation"*. S/Sgt. Bryant arranged with Victoria and Oak Bay Police Departments for coverage of calls but *"only for high*

priority emergency calls" (in the west by Victoria and in the east by Oak Bay PD).

1507 hrs:

- A/Sgt. Andy Stuart advised the other units (via radio) of the arrangements made for call coverage but that it was only for *"priority one calls"*.

1508 hrs:

- A/Sgt. Stuart's instructions were added to the 'remarks' of the stabbing CAD call that Victoria and Oak Bay Police units were available to cover but for *"priority one calls only"*.

1515 hrs:

- The Saanich dispatcher, D 1 telephoned S/Sgt. Bryant who confirmed that Victoria *"was available to assist"* but to keep that member *"clear for priority one calls only"*.

1620 hrs:

- Dispatcher D 1 was contacted by S/Sgt. Bryant who advised that *"nothing had changed and that all units were still tied up"*. Sgt. Makarewich's report stated *"S/Sgt. Bryant confirmed that the oncoming night shift early cars would be available for other calls and would not be tied up on the stabbing"*.

1715 hrs:

- S/Sgt. Bryant stated he *"turned the shift over to S/Sgt. Piercy"* and briefed him on the events of the day.

1729 hrs:

- Sgt. Makarewich's report stated that the dispatcher (D 1) had received a call from A/Sgt. Stuart inquiring as to *"how many early cars were on duty"*. He was advised that *"one early car plus an early NCO, Sgt. Dave Stephens"* were on. A/Sgt. Stuart *"advised dispatcher* D 1 *to only send the early car to calls that they can clear quickly* (that will not tie them up for any period of time)".

Additional Information:

1725 hrs:

- Cst. Fiona Reid signed onto CAD as the only 'early car'.

1728 hrs:

- Cst. Reid was dispatched to an 'unwanted person' call from the queue (10-30463).

1736 hrs:

- Ledger House reported 22(1) as missing (PRIME file10-30466).
- The call was classified as a *"priority 3"* response code and placed into the 'calls holding' queue.
- At this time three Oak Bay units were shown on the MDT as available.
- No Saanich units were available due to the stabbing investigation.

1737 hrs:

- Cst. Reid cleared the unwanted person call.

1739 hrs:

- Cst. Reid was dispatched to an 'animal call from the queue (10-30456).

1751 hrs:

- Cst. Justin Whittaker (K9) signed on and then immediately booked off at the municipal yard for *"training"*.

1803 hrs:

- Cst. Reid was dispatched to her third call, an 'alarm call', which Cst. Whittaker also attended as cover (10-30467).

1817 hrs:

- D 2 took over as dispatcher, relieving D 1 D 1 .

In summary, Cst. Reid was sent on two calls following the report from Ledger House regarding 22(1) Three Oak Bay units were available (but D 1 had been instructed to only deploy their services for *"priority one calls"*). S/Sgt. Bryant had already turned the 'watch' over to S/Sgt. Piercy and was off shift prior to the call from Ledger House being received and was not made aware of 22(1) disappearance until the following morning when he returned to work. S/Sgt. Piercy does not appear to have been aware of the missing person from Ledger House until 1910 hrs when Telecoms broadcasted her discovery and that she was *"deceased on the beach"*.

2011 Jan 17 Sgt. Reid informed S/Sgt. Dukeshire that [redacted 22(1)]

2011 Jan 19 1030 hrs - S/Sgt. Dukeshire reviewed all relevant policy relating to the 'Call Taker's Manual', 'Missing Persons' (OB180), 'Suicide' (OB240), 'Requests for Service' and 'Prioritization' of the various calls the department receives (OO30).

Call Taker Manual (Telecoms):

- The manual contains two sections specifically relating to missing persons. One for missing children and the other for *"missing persons"* in general.
- The manual does not define what constitutes a child, youth or adult. The Criminal Code differentiates between a child, young person and adult (children being under the age of 12, young persons being between the ages of 12 and 17, and adults being 18 years or older).
- Neither section in the manual speaks to call prioritization or dispatch requirements.
- The general *"missing persons"* section additionally addresses suicidal individuals and provides guidelines on what information should be sought but does not give any direction as to prioritization or dispatching calls in these cases.

Note: See **conclusion 12** for further comment and recommendation.

Operational Manual - Policy OB180 (Missing Persons):

- This policy does specifically define adults and youth and gives direction as to what should be done when either are reported as missing.

- The policy goes further and gives separate and clear direction as to what steps should be undertaken when *"suspicious or mitigating circumstances"* are present.

- *"Mitigating"* is defined as circumstances when the missing person is *"considered to be at an elevated level of risk due to age or diminished mental capacity"*.

- When such circumstances are known, section 4 of this policy directs *"Telecoms staff"* to;

  a) *"start a report in the usual fashion"*,

  b) *"immediately enter the missing person on CPIC"* and,

  c) *"assign the file to a patrol officer for immediate investigation"*.

Note: See **conclusion 4** for further comment and recommendation.

Operational Manual - Policy OB240 (Suicide):

- This policy gives direction as to what steps should be undertaken once the act of suicide has been committed. It does not bear any relevance to this report, specifically in relation to the review of the department's response when Ledger House first notified SPD of 22(1) disappearance. No concerns have been identified in relation to the department's response following the discovery 22(1) death.

Operational Manual - Policy OO30 (Requests for Service -

Prioritization/Response Codes):

- This policy details the procedures for receiving information/calls for service and how such calls should be *"ranked and classified"*, prioritized and dispatched.

- Sec. 2 directs that any calls *"requiring an operational response will be:*

  a) forwarded to a Telecoms operator,

  b) ranked and classified as either routine, urgent or emergency, and

  c) responded to in a manner required by the classification and nature of the call".

- Sec. 5 denotes the prioritization being either:

  - **Priority 1**: Emergency - Dispatch Immediately; attend immediately. Calls in which there is a high probability that death or grievous bodily harm will result.

  - **Priority 2**: Urgent - Dispatch as soon as possible; attend as soon as possible. Non-stackable calls.

  - **Priority 3**: Routine - Dispatch when unit available; attendance by the officer within one hour or complainant to be notified.

  - **Priority 4**: Non-Dispatchable or Referral - Calls not generally dispatched (e.g. telephone response or files conclude in first instance, such as stolen bikes) or referral to specialized police unit or social agency.

- Sec. 7 lists the various types of incidents including *"Missing Person(s)"*.

This section has four sub-categories, juvenile, adult, mentally incompetent and Elopees. The policy prescribes that all cases related to missing persons be classified as *"priority 2"*.

Note: See **conclusion 3** for further comment and recommendation.

2011 Jan 20

Jack Ledger House Reporting Protocols:

1100 hrs - S/Sgt. Dukeshire spoke with Detective Sgt. Reid in an effort to locate any information she may possess regarding Jack Ledger House reporting procedures/policy when a patient goes missing. Sgt. Reid attended the PSO and provided two documents that she had previously received from the Coroner, Michael Butler, which detail *"AWOL Procedures"* and *"Elopement"*.

Regarding the *"AWOL Procedures"*, a notation at the top of the document indicates that the procedures for missing patients were currently being re-written. Both documents do not indicate the timing of various protocols such as at what stage searches should be initiated or when during this process the family or police should be contacted. The documents do however, clearly indicate that upon the discovery of a missing patient, the staff will engage in significant searches of the buildings and grounds using equipment such as flashlights and radios and that certain staff members will be informed of the circumstances such as the *"nurse in charge"* (NIC) who in turn will notify other relevant staff members.

Further comment as to the procedures employed by the Jack Ledger House regarding missing persons is not necessary for the purposes of this review and is in fact, beyond the purview of the Saanich Police Department. Mention is made only in this regard to point out that it appears to be the practice/policy of Ledger staff to conduct/initiate their own searches and protocols before involving the family or police which occurred in this case (the purpose of this Professional Standards review is to assess the

department's response once the report had been first received and not to comment in any great detail on the practices and policies of Jack Ledger House).

S/Sgt. Dukeshire recognizes however, that the Saanich Police Department and Jack Ledger House have a working relationship and that communications have occurred between them and the Saanich Police Department since 22(1) death regarding missing person calls from that facility. That discussion appeared to have contributed to a directive being authored by Insp. Rhodes to Sgt. Makarewich (NCO - Telecoms) clarifying the prioritization of missing person reports from Jack Ledger House at least until the completion of this review (see attached directive – Admin Bulletin #44).

Meeting with A/Sgt. Stuart:

1300 hrs (approx) - S/Sgt. Dukeshire met with A/Sgt. Andy Stuart. S/Sgt. Dukeshire informed him of the review being undertaken by the PSO into the suicide involving 22(1) S/Sgt. Dukeshire asked A/Sgt. Stuart for clarification regarding his rationale/intentions in giving the direction to Telecoms regarding reserving dispatch to *"priority one calls only"*. A/Sgt. Stuart stated he wanted to ensure that the early car and the Oak Bay and Victoria units would remain free should a more serious call come in that would require immediate police attention which would have otherwise drawn from their already occupied resources with the stabbing investigation. His instruction was given approximately two and a half hours prior to the missing person call being received from Ledger House and was in the interests of personnel management at a time of high demand for police resources.

2011 Jan 24

Meeting with Sgt. Makarewich:

0700-0810 hrs - S/Sgt. Dukeshire met with Sgt. Makarewich to clarify some aspects of the roles played by various Telecoms employees, the CAD report and whether or

not she was in possession of any other evidence necessary for this review (ie: dispatch and radio transmission recordings). In summary she stated the following:

- The CAD (Computer Aided Dispatch) system automatically prioritizes missing persons as *"priority 3"*. A CAD document entitled *"Police Call Type Table/Summary"* describes only two scenarios; *"missing child"* (priority 1) and *"missing persons"* (priority 3).

- The Telecoms call taker (CT) can manually change that response code when the circumstances warrant it. CTs are trained to make their determinations based on the information they are being provided on a case by case basis.

- Normally when the CT changes a predetermined CAD response code there will be discussion between the CT and the dispatcher as to the reasons why.

- S/Sgt. Dukeshire pointed out the discrepancy between the CAD predetermined response code and SPD policy OO30 which requires all missing person calls to be designated as *"priority 2"*. Sgt. Makarewich recognized that issue.

- Sgt. Makarewich also indicated that CTs are generally aware of departmental policy relating to call prioritization.

- Sgt. Makarewich clarified the CAD report which showed D 3 as being situated at the *"clearance desk"*. She advised that D 3 was working the night shift and came on duty after the fact and played no role in the prioritization of the Ledger call.

- Sgt. Makarewich also advised that CT 2 and CT 3

who were working at the time the call was received from Ledger House, similarly did not play a role in the prioritization of the call.

- Sgt. Makarewich described her role and responsibilities as the Telecoms NCO. Among her duties she is tasked with:
    - conducting audio recording downloads (video was previously her responsibility as well but this had been reassigned to the front desk administrative constable some time ago),
    - data *"backups"*,
    - checking the server, and
    - departmental phone maintenance.
- Such tasks are time consuming and significantly limit her ability to directly supervise the activities of her civilian staff.

Note: See **conclusions/recommendations** for further comments regarding Telecoms supervision.

Radio Transmissions / Telephone Conversations:

Sgt. Makarewich advised that she has digitally saved all of the radio transmissions and telephone conversations related to this matter and that the file is considerable in size. S/Sgt. Dukeshire requested Sgt. Makarewich to locate and provide an emailed account of precisely what direction was given to Telecoms by S/Sgt. Bryant (by telephone - 1505 hrs) and A/Sgt. Stuart (by radio - 1507 hrs, and by telephone - 1729 hrs). S/Sgt. Dukeshire received an email from Sgt. Makarewich which provided the requested information. The email also provided information regarding an inquiry made by Sgt. Stephens as to what calls were in the dispatch queue and the Telecoms and Cst. Justin

Whittaker's response. Sgt. Makarewich's email stated the following:

1) Regarding a call to dispatch (D 1) from the Watch Commander's line (S/Sgt Bryant at 1505 hours).

- S/Sgt Bryant asked, *"anything of significance holding?"*
- The dispatcher responded, *"I have an animal call* (the call was described) *and the dispatcher explained that the staff have notified the caller that it will be awhile"*.
- S/Sgt Bryant stated, *"Yeah, it will be a couple of hours and anything of priority..."* (cut off by D 1).
- The dispatcher stated, *"I think the most important is an alarm at the Munroe Centre that has been holding for ½ hour"* (they discussed where the Munroe Centre is located).
- S/Sgt Bryant stated, *"Andy is checking with the city to see if they can assist with priority calls. Who is the Oak Bay Sergeant"* (They discussed that the OB Sgt is Ray Maxwell C55).
- S/Sgt Bryant stated, *"I will see if Oak Bay can handle the Oak Bay border"*.

2) Regarding A/Sgt. Andy Stuart's direction to the dispatcher (D 1) over the air (1507 hours).

- A/Sgt Stuart stated, *"Just spoke to VCP and probably have two units on our channel momentarily and use then for priority one calls"*.

- The dispatcher (D 1) acknowledged A/Sgt. Stuart's transmission.

- A/Sgt Stuart stated, *"...and as per S/Sgt Bryant, kinda' keep them for centre west and Oak Bay will cover the east"*.

- The dispatcher acknowledged this direction.

3) Regarding A/Sgt. Stuart's direction to the dispatcher (D 1) over the phone lines (1729 hours).

- A/Sgt. Stuart stated, *"Do you have one early car or two?"*

- The dispatcher responded, *"I have one signed on right now and Dave Stephens is on as well. He is 50. I just don't know if it is him plus somebody else or he is the other one"*.

- A/Sgt. Stuart stated, *"Maybe. No problem sending them to what you send them to. Make sure their going to calls where they can kinda bail on it if they need to because I don't think we have anyone clear do we?"*

- Dispatcher D 1 responded, *"Yeap...um...no...yeah the unwanted he might be..."* (Disp. D 1 was cut off by A/Sgt. Stuart).

- A/Sgt. Stuart stated (muffled), *"it's probably GOA"*.

- The dispatcher stated, *"Yeah I'll send him the GOA's"*.

- A/Sgt. Stuart stated further, *"even if an unwanted and even if your just talking to some bum then at least drive away if we have a domestic or something right"*.

- The dispatcher stated, *"Yeah I have a B and E and I'm going to leave that*

and we have already called them and told them it's going to be awhile".

- A/Sgt. Stuart then complimented the Telecoms staff on how they handled the stabbing incident.

4) Regarding Sgt. Stephens asking dispatch (D 2) regarding what calls were in the queue (1829 hours) and Cst. Justin Whittaker advising of the priorities of the calls holding in the queue.

- Sgt. Stephens asked, *"Saanich 50, do we have any calls in the queue right now?"*
- The dispatcher (D 2) responded, *"10-4 quite a few"*.
- Sgt. Stephens stated, *"Okay I will see if I can get some guys to come out early now"*.
- The dispatcher acknowledged Sgt. Stephens' comment.
- Cst. Whittaker came on the air and interjected stating, *"B50, K3* (Sgt Stephens acknowledged this call from Cst. Whittaker), *just so you know they are all priority 3 and 4's"*.
- Sgt. Stephens responded stating, *"10-4 thanks"*.

2011 Jan 26 **Meeting with Sgt. Dave Stephens**:

1045 hrs - S/Sgt. Dukeshire met with Sgt. Stephens and discussed his radio transmission to Telecoms asking what calls were in the queue. In summary he stated the following:

- Sgt. Stephens stated he was in the 'road supervisors' office at the time he

made the radio request for the information (he was in the early stages of his night shift and had only been on duty for approximately 1 hour).

- The time of his radio request (1829 hrs) was during shift change and he was aware that the day shift units were tied up with the stabbing investigation.

- He stated that the supervisor's office does not have access to CAD which is why he requested the information from Telecoms.

- Without having access to CAD at that particular moment Sgt. Stephens would have been unable to personally assess the details of each of the queued calls. With this in mind, Sgt. Stephens stated his opinion that the road supervisor's office should be equipped with access to CAD so that they can personally review all calls while in the office (queued and active calls).

- Being unable to assess each call directly, Sgt. Stephens accepted the information he had received from Cst. Whittaker and Telecoms.

- Sgt. Stephens stated he made the inquiry with Telecoms while giving consideration to freeing up officers from his shift as they became available and as they reported for duty for the oncoming night shift.

Note: See **conclusion 13** for further comment and recommendation.

2011 Feb 01 **Call Taker** CT 1

S/Sgt. Dukeshire spoke with CT CT 1 (by telephone). In summary she advised the following:

- She felt 22(1) tone/demeanour was calm and that there *"wasn't any urgency in her voice"*.

- CT 22(1) recalled being aware that 22(1) had informed her that 22(1) was a *"risk to harm herself"* and that she had recently had *"suicidal thoughts"*.

- The above, in combination with the information relating to 22(1) admission to the 22(1) Hospital the night before, had *"triggered"* CT 22(1) at the time to think that 22(1) might be *"suicidal now"*. CT CT 1 however, felt this was mitigated somewhat by the information that 22(1) had self admitted herself and was apparently *"intoxicated"* at the time of the admission.

- CT CT 1 stated she felt the information she received and based largely on the routine manner in which 22(1) reported 22(1) disappearance, did not warrant an *"upgrading"* of the automatic CAD prioritization of *"3"* to a higher priority (she further cited 22(1) response when informed that it may be some time before an officer would be able to attend, by saying *"no worries"* (although the meaning is the same, it is known from the recordings that the precise wording was *"no problem"*).

- Some discussion was had regarding departmental policy (OO30 and OB180) of which CT CT 1 was aware but not in great detail.

- CT CT 1 recalled receiving earlier instruction from S/Sgt. Bryant regarding the availability of Victoria and Oak Bay units (due to the stabbing investigation which occupied all resources) but to not deploy their

services except for high priority events.

- She stated his instruction did not play any role in her prioritization of this call as level 3.

- CT CT 1 felt the automatic prioritization assigned by CAD to the missing person call was appropriate for the circumstances (again, based primarily on the manner in which 22(1) made her report with no sense of *"urgency"*).

2011 Feb 02 **Dispatcher D 1**:

S/Sgt. Dukeshire spoke with CT/Dispatcher D 1 (by telephone). In summary she stated the following:

- On Dec. 19/10 she worked both as a call taker and as dispatcher. She believes her sole responsibility during the last half of her shift was as the dispatcher (at time of the call from Ledger).

- She described the process of prioritization as a collaborative effort between the call taker and the dispatcher but that the call taker would have a degree of additional information or sense of the call from speaking directly with the caller (i.e. the caller's demeanour or other subtle information that might not necessarily be reflected in the 'call remarks' etc.)

- D 1 stated she felt the call from Ledger had a *"more important"* ring to it than *"other standard missing persons calls"* but based on the call coming to her prioritized as '3' in combination with the instruction Telecoms had earlier received from S/Sgt. Bryant and A/Sgt. Stuart regarding keeping units free for *"priority 1 calls only"* she felt the call was

suitably prioritized and could remain in the queue until more units were available.

- She stated that calls come to the dispatcher already prioritized but despite that she reads the information attached to the calls ('call remarks') and regardless of how a call is prioritized she will dispatch officers if she feels she has the available resources and the call warrants it at that time.

- She recalled sending the lone early car on two calls that she felt could be cleared quickly, again considering the instruction she had received from S/Sgt. Bryant which she interpreted to mean keeping units available for high priority calls.

The above represents the major findings from this review. There are other inconsequential facts contained in the Professional Standards database case notes regarding the investigative steps undertaken by S/Sgt. Dukeshire however, for the purposes of this report they have been left out as they are unnecessary.

Please see the following conclusions and recommendations.

ANALYSIS / CONCLUSIONS / RECOMMENDATIONS

Re: Attempt Murder Investigation (10-30455)

1. On December 19, 2010 at 1419 hrs, C Platoon (dayshift) responded to a serious incident which demanded the shift's full attention and occupied each member with tasks that were *"critical"* to maintaining the *"integrity"* of that investigation. The incident involved a stabbing which ultimately led to Criminal Code *"attempt murder"* charges against the suspect in that case (PRIME file 10-30455 refers). In anticipation of the potential for other calls that might require an immediate response, S/Sgt. Bryant and A/Sgt. Andy Stuart arranged for 'stand-by' assistance from both Victoria and Oak Bay Police departments.

   Additionally, they both gave direction to the Telecoms staff to use those additional resources only for *"high priority"* calls. The purpose of this direction was to ensure that in the event of such a call the units already occupied with the stabbing investigation would not be drawn away and could remain on task.

   S/Sgt. Bryant's and A/Sgt. Stuart's management of personnel was appropriate and was made well in advance of the events involving Jack Ledger House and 22(1)

Re: Jack Ledger House Reporting Procedures

2. It is not within the purview of this review to assess or otherwise judge the merits of the protocols employed by Ledger House relating to missing persons and the manner in which they report such incidents to the police. From this review however, it can be said that a delay did occur from the moment 22(1) was first observed to be missing to the time her disappearance was reported to the Saanich Police Department. The timeframe is not precise but appears to be between 35 to 45 minutes.

It also appears that the Ledger House staff's response to 22(1) disappearance was in keeping with their standard practices and policies which involved searching the buildings and grounds and notifying selected staff before contacting the family and police.

Re: Saanich Police Policies OB180 v. OO30 - Recommendation 1

3. The relevant Saanich Police policies governing police response to reports of missing persons are OB180 and OO30. OB180 provides direction as to what steps are required upon receipt of a missing person call (such as generating a 'general occurrence' file and entering information onto CPIC) while OO30 specifically defines the response codes by assigning 'priorities' for all calls for service including missing person calls.

   As pointed out by Insp. Green in his January 11, 2011 email to the other Saanich Police senior officers, there are *"inconsistencies"* between these policies in terms of dispatching and prioritizing calls relating to missing persons. Insp. Green cited policy OB180 which directs that certain *"routine"* missing person calls could be referred to either the Youth or Detective divisions (depending on the age of the missing person) without patrol involvement or attendance which by definition is a *"priority 4"* response. Yet policy OO30 indicates the prioritization of all missing person calls will be considered *"priority 2"* which by definition requires *"dispatch"* and police *"attendance as soon as possible"*. Insp. Green's email further suggested policy change but did not provide specific instruction on what the actual amendment should be.

   Recommendation 1:

   - S/Sgt. Dukeshire agrees with Insp. Green's call for policy change involving these sections. In the interests of bringing policies OB180 and OO30 more in line with one another it is recommended that the amendment be made to OO30, section 7. It is S/Sgt. Dukeshire's position that the current policy should stand and that all missing person calls should be prioritized as *"priority 2"* or higher (save for referrals, ie: involving chronic runaways, group home scenarios with no identified or significant

risk factors). Based on the above the amendment could be as simple as adding a 5th sub-category to the missing persons classification as follows:

- *"Non-Dispatchable/Referral (no suspicious/mitigating circumstances as per Operational Policy OB180) – priority 4".*

Note: Regarding all other missing person calls being assessed *"priority 2"* or higher, further comment is made in the following conclusions and recommendations.

Re: Policy OB180 – "Mitigating Circumstances" - Recommendation 2

4. Policy OB180 speaks of *"suspicious or mitigating circumstances"* which, if identified in any particular report of a missing person, could alter the police response. OB180 defines *"mitigating"* as when a missing person is *"considered to be at an elevated level of risk due to age or diminished mental capacity"*.

   To S/Sgt. Dukeshire, the term *"diminished mental capacity"* suggests an individual who may be less than fully capable of caring for themselves (not necessarily someone intent on harming themselves or others but rather, simply mentally incapable or deficient in that regard). It appears that 22(1) was fully capable of caring for herself in terms of being able to function from day to day therefore, in the strictest sense, she did not fit this definition. 22(1) was however, at risk of harming herself and therefore could reasonably be seen as not of sound mind and in a broader sense, could then arguably be described as being in a state of diminished mental capacity. With this in mind, the current policy's terminology is subject to individual interpretation and could benefit from clarification.

   Recommendation 2:

   It is recommended that the definition of *"mitigating circumstances"*, located in policy OB180 immediately preceding section 4, be expanded as follows:

- *"For the purpose of this section, the term 'mitigating' applies to persons who are considered to be at an elevated level of risk due to age or diminished mental capacity or are at risk of harming themselves or others".*

From this review it is S/Sgt. Dukeshire's position that policy OB180 is otherwise appropriately worded and contains sufficient direction for the handling of missing person calls.

Re: Policy OO30 v. CAD Automatic Prioritization - Recommendation 3

5. Further discrepancy has been identified between Saanich Police policy OO30 and the automatic CAD classification system. When missing person calls are received and corresponding general occurrence files are created in PRIME, the CAD system automatically classifies the call as *"priority 3"* and therefore requires a manual adjustment in order to be in compliance with Saanich operational policy (which, as detailed in **conclusion 2** above, directs that all missing person reports will be characterized as *"priority 2"* with the lone exception being the case of known routine and/or chronic runaways). Nowhere in SPD operational policy is direction ever given to classify missing person calls as *"priority 3"* however, as stated earlier, policy OB180 speaks of *"routine"* missing persons which involves no police attendance but rather a referral to either Youth or Detectives which, by policy OO30, is classified as a *"priority 4"*.

   S/Sgt. Dukeshire reviewed a history of twenty five (25) reports of missing persons from Jack Ledger House between 2007 and 2010 (provided by Cst. Underwood of the Research and Planning section – not including this file). Nineteen (19) of those calls were classified as *"priority 3"*. Eight (8) of the files classified as *"priority 3"* spoke of *"high risk"* factors, suicidal markers and other comments such as *"at risk of harm"* yet the classification remained at *"priority 3"*. As stated above, although Saanich operational policy does not provide for any missing person calls to be classified as *"priority 3"* it appears this response code is used relatively frequently relating to missing person calls. Although research has not

been conducted regarding missing person calls from the community at large, it would be reasonable to expect that many of those would also have been assigned a *"priority 3"* response code which, on the surface, would be contrary to current policy.

Particularly when there is any mention of known risk factors being present, it appears to S/Sgt. Dukeshire that the appropriate approach should be either a *"priority 2"* or *"priority 1"* response. Placing such calls into a holding queue is not sound practice and it appears foreseeable that doing so could reasonably draw criticism if it became known to the general public.

Regarding the prioritization of calls received from Ledger House:

The circumstances of 22(1) death and the initiation of this review, led to Insp. Jamie Rhodes giving interim direction to Telecoms (via Administrative Bulletin #44, effective January 11, 2011) that *"until further notice all reports of persons missing from Jack Ledger House will be classified as Priority 2"*.

Recommendation 3:

It is S/Sgt. Dukeshire's recommendation that Insp. Rhodes' direction as per Administrative Bulletin #44, should remain in effect permanently and does, in fact, reflect what current policy already calls for (see further comment in the remaining conclusions).

It is recognized that not all calls from Ledger House will always have 'high' or even any risk associated to the missing person, however, given the nature of the facility, dispatch *"as soon as possible"* and attendance to the call by an officer in the first instance should occur in order to assess and determine what action or follow up, if any, might be required (see **conclusion 7** below for further comment).

Re: Policy OB240 and Police Response to 22(1) Reported Suicide

6. A third Saanich Police policy, OB240, addresses *"suicide"* and provides direction as to what investigative steps are required once the act of suicide has been committed. From this review no concerns have been identified in relation to the department's response following the discovery of 22(1) death. All actions and subsequent investigation appears to have been thorough and appropriate in nature.

Re: Prioritization of Missing Person Calls - Recommendations 4 and 5

7. Regarding reports of missing persons received from the community at large:

   Current policy suggests that the Saanich Police Department's historical approach to such calls has been to treat all missing person calls as warranting a *"priority 2"* response or higher (as reflected in policy OO30). Current practices as described in **conclusion 5** above indicate that our department is routinely classifying missing person calls as *"priority 3"* seemingly contrary to policy.

   It is S/Sgt. Dukeshire's belief that *"priority 4"* responses continue to be appropriate as per current practices relating to chronic runaways from institutions such as group homes and the like where a clear historical pattern is established.

   It is however, S/Sgt. Dukeshire's position that the police response to all other reports of missing persons, whether it be from an institution such as Jack Ledger House or a private household, should be classified no less than *"priority 2"* in all cases. This approach simply dictates that dispatch will occur *"as soon as possible"* and that attendance will occur *"as soon as possible"*. Certainly in the case of institutions such as Ledger House and Seven Oaks there will be occasions where the response code will be even higher however, in most cases, *"priority 2"* simply ensures that our department will respond *"as soon as possible*".

   It is S/Sgt. Dukeshire's opinion that the average home that feels the need to report a missing family member to police (with no evidence of past or chronic reports) should receive the

benefit of police dispatch and attention to their call at the earliest available opportunity. The notion of dispatching members to true *"priority 3"* calls (as currently listed in policy OO30) prior to any missing person call no matter how routine in appearance, seems inappropriate. As stated in **recommendation 3** above, the purpose of the initial police response is simply to assess and determine what action or follow up, if any, might be required and that police attendance will occur as soon as a member is available. See **recommendations 4 and 5** below for further comment:

Recommendation 4:

It is S/Sgt. Dukeshire's recommendation that the Saanich Police Department should discontinue the current practice of allowing the automatic CAD classification of missing person calls to stand as *"priority 3"*. All missing person calls should be classified as *"priority 2"* or higher (save for the routine/chronic runaway as already discussed) reflecting the department's philosophy that all missing person calls are considered important and warrant dispatch and assignment to an officer at the earliest availability.

Recommendation 5:

Regarding the phrase *"attend as soon as possible"* as stated in policy relating to *"priority 2"* response codes; it is recommended that this should be viewed as not necessarily meaning physical attendance at the complainant's home or business in all cases but rather, the call itself being 'attended to' as soon as possible. Being *"attended to"* may simply involve an officer establishing contact with the complainant by telephone or other means in the first instance depending upon the circumstances.

It is recognized by S/Sgt. Dukeshire that the vast majority of missing person calls end with the subject being located or simply returning on their own and that the tragic circumstances such as the case of 22(1) are the exception. However, when viewing missing person calls from the perspective of an individual reporting a family member or other person as missing, a response from a police officer at the earliest opportunity, whether it be

by telephone or physical attendance at the complainant's home, should be a service the residents of Saanich can rely upon and expect.

Re: Administrative Bulletin #45 - Recommendations 6, 7 and 8

8. An *"update"* to Administrative Bulletin #44 (detailed in **conclusion 5** above) was published and came into effect on February 4, 2011 (Admin. Bulletin #45) which detailed three *"categories"* of missing persons. The word *"category"* is terminology used by Jack Ledger House within their policies and protocols. As currently worded in the Saanich Admin. Bulletin #45, the use of the term *"category 1, 2 and 3"* might naturally be translated by Saanich Police employees (Telecoms staff and police officers) to mean *"priority 1, 2 or 3"*.

   Particularly if the recommendations in this report to this point are accepted (i.e. discontinuing the practice of classifying any missing person calls as *"priority 3"*), then it is foreseeable that the bulletin, as it currently stands, could cause some degree of confusion.

   Recommendation 6:

   It is recommended that Admin. Bulletin #45 be amended to include Telecom staff being informed that the word *"category"* is terminology used by Jack Ledger House and that the term should not be confused as being synonymous with Saanich Police response codes.

   Recommendation 7:

   It is recommended that Admin. Bulletin #45 be amended relating to the dispatch instruction given at the end of each *"category"* to state, *"...will be classified as priority 2 or higher and dispatched accordingly"*.

   Recommendation 8:

   It is recommended that page 2 of Admin. Bulletin #45 be amended further to state, *"Telecom staff will review Operational Policy OO30 relating to missing persons when the*

Dispatch Priority is unclear. If after reviewing policy OO30 the Dispatch Priority remains unclear, Telecom staff will consult a patrol NCO".

Re: 22(1) and CT CT 1

9. Regarding the call from Ledger House to the Saanich Police Telecoms centre on December 19, 2011 (the Ledger employee who reported 22(1) disappearance was 22(1) - the Saanich call taker (CT) receiving the call was Ms. CT 1):

22(1) voice and demeanour was very calm and she did not give or indicate any sense of urgency or express a need for immediate police attendance. Despite giving information regarding 22(1) physical condition *("unstable on her feet"),* that 22(1) had recent *"suicidal ideations"* and was *"at risk of hurting herself"*, this review has determined that the manner and tone in which 22(1) reported 22(1) disappearance did influence CT CT 1 decision to classify the call as *"priority 3"*. This is supported by S/Sgt. Dukeshire's discussion with CT CT 1 on February 1, 2011.

The *"risk"* of harming herself was not expanded upon (i.e. low, moderate or high) and other pertinent information was not provided by 22(1) which was known to Ledger House at the time, specifically that 22(1) had expressed a clear plan to commit suicide upon her release from Ledger House which was anticipated to be sometime in January 2011. Further, when advised by CT CT 1 that it *"it might be a little bit"* before police would be able to attend, 22(1) responded stating, *"No problem"*, adding to the routine appearance of the call.

Despite such things as tone of voice and calm demeanour, it is S/Sgt. Dukeshire's position that the actual information being received must always be given careful consideration and may in some cases, prompt a higher police response regardless of the disposition or wishes of the caller. The critical question in this case is, was the information that was provided by 22(1) sufficient to warrant a higher response than *"priority 3"*, or conversely, did the information that was provided warrant a reduction in prioritization to *"priority 3"* from

"priority 2" which is the normal response code for such cases as prescribed by the existing departmental policy?

It is S/Sgt. Dukeshire's position that the information received, although incomplete and with significant omissions of relevant and significant information (22(1) voiced plan to kill herself upon release from Ledger House) and despite the routine demeanour of 22(1) , was sufficient enough to minimally warrant a *"priority 2"* response as called for by policy OO30. This is based on the information that *was* provided by 22(1) ; 1) describing 22(1) as having *"suicidal ideations"* as recently as *"last night"* [Dec. 18/11], 2) that 22(1) was *"at risk of hurting herself"* and 3) that Ledger House staff had observed 22(1) to be *"unstable on her feet"*.

Despite the above, it is S/Sgt. Dukeshire's position that this review has found no evidence that would support any allegation or suggestion of misconduct or improper behaviour on the part of CT CT 1 in classifying the call as a *"priority 3"* (although seemingly contrary to policy and in spite of the information she received from 22(1)). CT CT 1 is a respected Telecoms staff member who was acting in good faith and to the best of her abilities while facing challenging deployment issues at the time of 22(1) reported disappearance.

In a recent decision by the B.C. Police Complaint Commissioner, Mr. Stan Lowe, regarding an unrelated conduct matter, his comments were as follows;

- *"It is clear from reliable evidence that the Officers were lawfully engaged in their duties, and they were acting in good faith… There was no demonstrable oblique or nefarious motive suggested by any of the evidence. This event was dynamic and the officers were forced to make decisions quickly as matters unfolded"*.

- *"I am not convinced that the conduct of the Officers exhibited the degree of moral blameworthiness necessary to constitute misconduct pursuant to the Act"*.

It is S/Sgt. Dukeshire's position that the Commissioner's comments are relevant and could quite easily be applied to this matter. Where he mentions *"officers"*, the reference could be replaced with *"Telecoms staff"*.

Additionally, what is evident is the convergence of a number of unfortunate events including, but not limited to:

- a strain on the available resources due to a serious but unrelated investigation,
- the dynamics of shift change,
- the management of available units and other incoming calls for service,
- the manner in which the call was reported by Ledger House (seemingly routine in nature with little or no sense of urgency), and,
- the past and apparently accepted practice of assigning *"priority 3"* response codes to previous similar cases.

Re: Dispatcher D 1

10. For the reasons as detailed in **conclusion 9** above, this review has similarly found no evidence that would support any allegation or suggestion of misconduct or improper behaviour on the part of the dispatcher, D 1 in placing the initial call from Ledger House in the 'queue' as a *"priority 3"* call. As CT CT 1 D 1 is a respected Telecoms staff member.

Re: S/Sgt. Bryant and A/Sgt. Stuart

11. Similar to **conclusions 9 and 10** above, this review has found no evidence that would support any allegation or suggestion of misconduct or improper behaviour on the part of S/Sgt. Bryant and A/Sgt. Stuart in providing direction to Telecom staff to only use Victoria and Oak Bay units for *"high priority"* calls. To the contrary, their instructions were well in

advance of any issues relating to 22(1) and Ledger House and were an appropriate measure to ensure the availability of resources should another significant event occur which would require an emergency response by police.

Re: Call Taker Manual - Recommendation 9

12. Regarding the 'Call Taker Manual':

From this review it has been found that although recent Administrative Bulletins #44 and #45 speak to the prioritization and dispatch requirements relating to individuals from Ledger House, the Call Taker Manual itself does not speak to the prioritization or dispatch requirements as it relates to missing person calls.

Recommendation 9:

It is recommended that the Call Taker Manual be amended by drawing the call taker's attention to the departmental Operational Manual, directing them to follow the procedures, as outlined in the relevant sections (OB180 and OO30) relating to missing person call prioritization. This recommendation is made only in the spirit of refining the manual but is not intended to suggest that without this amendment the existing manual was critically flawed or in any way contributed negatively to the case involving 22(1)

Re: Sgt. Dave Stephens - Recommendation 10

13. Sgt. Dave Stephens was the oncoming night shift road supervisor for December 19, 2010. The road supervisors have a self contained office with 2 computer terminals where they prepare for the commencement of their pending duty. It is known from this review that Sgt. Stephens was unaware of the call from Ledger and made an inquiry at 1829 hrs by radio from the supervisors office as to what calls were currently being held in the queue. He received a response from the dispatcher that *"quite a few"* calls were currently holding. He also received information from Cst. Justin Whittaker, who was in his police vehicle and had access at the time to an MDT (Mobile Data Terminal). Cst. Whittaker advised Sgt. Stephens

that the calls holding were *"all priority 3 and 4's"* thereby implying that immediate dispatch or attention was not required. No further inquiries were made by Sgt. Stephens as to the details of those calls.

Sgt. Stephens' inquiry was in the interest of determining whether or not he should make more units available as they arrived for duty for the calls that were holding in the queue. Sgt. Stephens' inquiry was appropriate and the information he received in return appeared to indicate that no calls of any urgency (that might require a prompt police response) were holding at the time. Without access to the Computer Aided Dispatch system (CAD) Sgt. Stephens could not personally look further into the details of the calls and he accepted the information he had received from Telecoms and Cst. Whittaker at face value.

On this occasion Sgt. Stephens was the early Sergeant and his primary duty at that time was to organize reports and information from previous shifts in preparation for 'muster' which is an information-sharing meeting that occurs at each shift changeover. Among his other duties is to be aware of calls held over from the day shift which might affect the deployment and management of his own personnel who were about to commence their shift.

From the circumstances in this case and during his interview with S/Sgt. Dukeshire, Sgt. Stephens expressed his opinion that it would be beneficial for the road NCO's office to have at least one terminal that would provide access to CAD which would greatly assist the road supervisors with their awareness of what is taking place on the road and in their preparation for their pending shift.

Recommendation 10:

S/Sgt. Dukeshire agrees with Sgt. Stephens' call for access to CAD in the road NCO's office and it is recommended that this take place at the earliest opportunity. Although Sgt. Stephens points out that often two road NCOs share the office and that access to CAD on both terminals would be ideal, it is suggested that if costs or licensing issues are a factor in

approving or not approving this recommendation, that one terminal would be a suitable starting point.

With the addition of CAD accessibility in the patrol NCO's office and by making it an added responsibility of each incoming 'early' sergeant to review and assess all active and queued calls during shift change, it would provide enhanced supervision of Telecoms operations.

14. None of these recommendations are intended to suggest that the manner in which the call was received, prioritized or stored in the queue contributed in any way to 22(1) suicide. From discussion with the Coroner, it is known that the time of 22(1) death cannot be determined with any degree of precision. It appears from the evidence in its entirety that 22(1) was focused on taking her own life and that determining the timing of her demise in relation to the report being made to the police and the subsequent police response is a difficult, if not impossible task for this review to address.

    The question at the very heart of this review appears to be whether or not 22(1) life might have been saved had the call from Jack Ledger House to the Saanich Police Department been responded to in a timelier manner? It is unknown what investigative steps could be undertaken that would provide a definitive answer to that question and any further comment would be purely speculative.

    From the available evidence however, it does not appear that the actions of any employee of the Saanich Police Department or the operations of the department in any way could reasonably be seen as contributing or having any form of causal link to 22(1) death.

S/Sgt. K. Dukeshire #97
Saanich Police Department
Professional Standards Office
Investigator

Report Reviewed by:
Chief Constable Mike Chadwick #307
Saanich Police Department
Discipline Authority

LIST OF ATTACHMENTS

1. Operational Policy OB180
2. Operational Policy OO30
3. Operational Policy OB240
4. Administrative Bulletin #16
5. Administrative Bulletin #18
6. Administrative Bulletin #33
7. Administrative Bulletin #44
8. Administrative Bulletin #45