Major Case Management Review
Saint John Police Force

Approved by:

New Brunswick Police
Commission

April 22, 2020

NBPC
NEW BRUNSWICK
POLICE COMMISSION

CPNB
COMMISSION DE POLICE
DU NOUVEAU-BRUNSWICK

Purpose of report

This report presents the findings of the NBPC quality assurance review team comprised of Executive Director Jennifer Smith and Senior Consultant Rick Votour. The on-site portion of the review was conducted at the Saint John Police Force headquarters at One Peel Plaza in Saint John, New Brunswick during the week of January 20th to 24th, 2020. Specifically, the review team examined a series of major crime incidents that occurred between 2014 and 2019 and involved crime scene management and processing to determine if the SJPF is conforming to policies, procedures and known best practices.

Introduction

On July 7, 2011 Richard Oland was found murdered in his office in downtown Saint John, New Brunswick and the Saint John Police Force (SJPF) launched an investigation.

The investigation of Richard Oland's death included the extensive use of internal and external specialized services and a consultation with the Office of Investigative Standards and Practice and the Serious Crime Unit of RCMP's "E" Division who conducted a review of the Oland investigation between October 9-13, 2012, with a focus on evidence gathered, avenues of investigation and evaluation of potential suspects.

On November 28, 2012 and October 11, 2013, the SJPF held case consultations with crown prosecutors from the Department of Justice and Office of the Attorney General who reviewed the file and approved a charge of second degree murder. On November 12, 2013, Richard Oland's son, Dennis Oland, was arrested and eventually presented for trial before a judge and jury.

On December 19, 2015 Dennis Oland was found guilty despite trial Justice Jack Walsh identifying the following four issues regarding the overall police investigation relating to crime scene processing and crime scene management:

1. Failure to properly secure against too many unnecessary entries into the crime scene.
2. Failure to secure washroom on second floor; used by unknown number of people.
3. Failure to ensure exit to alleyway remained untouched until it could be examined fully.
4. Failure to have pathologist consider whether a dry-wall hammer could have been murder weapon.

On December 23, 2015 the Saint John Board of Police Commissioners (SJBPC) requested that the New Brunswick Police Commission (NBPC) *"complete a review of the Saint John Police Force's investigation of the Dennis Oland case, specifically to address the areas of question that were brought forward by Justice John Walsh, in his instructions to the jury. The review should highlight measures that have already been taken by the SJPF since that time, and any other areas that may still require improvement in process, procedure, protocols or communications practices in conducting investigations."*

The NBPC review was suspended pending the successful appeal by Dennis Oland for a new trial based on an error in Justice Walsh's instruction to the jury.

On July 19, 2019, Justice Morrison acquitted Dennis Oland and in his acquittal of Dennis Oland stated that the "*failings of the police investigation, highlighted by the Defence, although considered by me, do not weigh heavily in the final determination of this case.*"

Public Prosecutions made the decision not to appeal the acquittal and NBPC reactivated the suspended review with the goal of assessing the actions taken by SJPF since the Oland homicide to address Justice Walsh's concerns and to ensure the public's confidence in the SJPF's ability to respond to and investigate a major crime incident, like a homicide.

As a first step, the Commission asked SJPF in August 2019 to identify and provide documentation that outlined actions SJPF had taken since 2011 to strengthen their crime scene management processes.

During and following the Oland murder in 2011 the police force made adjustments and improvements to respond to major crime incidents that included creating MCM Business Rules and invoking changes in procedures and roles for both primary response (patrol) and the specialized investigative units responding to and protecting crime scenes. The SJPF MCM business rules prepared by Staff Sergeant Sean Rocca of the MCU team set out the importance of the MCM command triangle that consists of the Team Commander, Primary Investigator and File Coordinator. Briefings were provided to patrol platoons to ensure crime scenes were protected immediately on police arrival and that access to crime scenes was strictly managed. SJPF policy on Human Deaths was revised and training was provided to members of SJPF specialized sections such as the major crime unit and forensics identification section.

After reviewing the documentation, the NBPC established an action plan to conduct an on-site review at the SJPF which was completed on January 24, 2020.

SJPF Criminal Investigation Division (CID)

The SJPF CID, led by an Inspector, is responsible for investigating major crimes that require extensive follow-up by investigators since such investigations are time consuming, time sensitive and generally complex in nature. Such crimes can often involve death, serious personal injury, significant loss of property, or may involve recurring criminal activity (e.g., repeated break and enters in a geographical area). The CID is made up of various units that include the Major Crime Unit (MCU) which consists of one Sergeant and nine investigators at the Constable rank with expertise, experience and specialized training in investigating homicides.

Major Case Management (MCM)

MCM in law enforcement refers to using methodologies and technology to investigate certain complex incidents and crimes that often creates an intense public demand for identification, apprehension and prosecution of the offender. Major cases such as homicide almost always fall into this category of complexity due in large part to the substantial commitment of resources required

for a prolonged period and the considerable volume of information of that must be catalogued, analyzed and actioned.

In New Brunswick, all police forces faced with a complex crime must be prepared to launch investigations with a disciplined approach to investigation by following a systematic method that standardizes how evidence and information is collected since data must be generated for a multitude of purposes. The *Policing Standards – Province of New Brunswick* (*Policing Standards*)[1] issued by the Minister of Public Safety pursuant to section 1.1 of the *Police Act*, states that "*Police forces shall maintain an operational records management system approved by the Director of Policing Standards and Contract Management*" and that "*Police forces shall provide or have access to specialized services on a 24-hour basis*" which includes specialized services for major/ serious crime investigations. The *Policing Standards* do not address MCM. A review of the New Brunswick *Municipal/ Regional Police Forces Operational Manual Human Deaths Policy* (Chapter 4.6), that applies to all municipal police forces, includes a reference to the *Canadian Police College Major Crime Management Manual* Sixth May 2002 Edition, however there is no provincial Operational Manual policy that addresses MCM.

MCM approaches to complex crimes and incidents have been around since the mid 1980's with origins in the UK. In Canada the Royal Canadian Mounted Police (RCMP) utilize *Evidence and Reports III* (E&RIII) electronic case management software to manage its MCM approach to serious crime. In the province of Ontario all police services use a computer software system call *Powercase*. New Brunswick Municipal police forces take their own approach to managing major crime incidents by utilizing their operational records management systems (RMS), which is *Versaterm* for all police forces except SJPF. The SJPF utilize the *Navaline Crimes RMS* supplemented with a SJPF Task Log cataloging system (paper and electronic).

Review methodology

The investigative quality assurance issues raised by Justice Walsh during the Oland investigation relate to crime scene processing and crime scene management. The SJBPC request to the NBPC was to determine if the issues raised by Justice Walsh have been addressed by the SJPF.

The Oland investigation itself has been extensively reviewed by various experts as evidenced by SJPF submissions to the NBPC in August 2019. During the Oland investigation the SJPF utilized internal and external specialized services in addition to an independent review by the Office of Investigative Standards and Practice and the Serious Crime Unit of RCMP's "E" Division. Further, expert witnesses testified and were cross-examined by an experienced criminal defense team during the two trials. For these reasons the NBPC review focused on the current MCM practices of the SJPF.

Quality assurance and quality control during a major crime incident are different but both are a required part of MCM quality management. Quality assurance is process focused and quality control is end-product focused; put another way, a police force must follow established policies, procedures and standards in order to achieve the best possible investigative outcome.

[1] Policing Standards, OPS 3.1 and 3.11

The NBPC quality assurance review team focused on reviewing all homicide investigations that occurred between 2014 and 2019 to determine if current SJPF MCM practices meet the high standard expected of a police force in responding to a major crime incident. In addition to the eleven homicide cases reviewed, a random sampling of twenty sudden death incidents that were either suicide or sudden death non-suicide were examined to evaluate the SJPF response to human death scenes that require adherence to crime scene policies and best practices until criminality is ruled out.

To enable capturing and analyzing collected data, a Matrix for SJPF Major Case Management (MCM) was created using criteria that included accepted practices from the Canadian Police College (CPC) Major Case Management Manual © and SJPF Major Crime Unit business rules as well as SJPF Major Crime Unit /Patrol guidelines. A total of 49 points of data across seven investigative and process categories was collected and analyzed. A separate Review Guide and Matrix for sudden death investigations was created for the SJPF using criteria sources that included *Municipal/ Regional Police Forces Operational Manual*, *Policing Standards - New Brunswick (Policing Standards)* and SJPF *Human Deaths Policy*.

Chief Bruce Connell provided full access to all required personnel, assets and records. S/Sgt David Brooker and S/Sgt Sean Rocca provided logistics support. The review included interviews of several key SJPF employees with knowledge of crime analysis, policy development, major crime management, patrol and forensics.

Sudden death file review

The SJPF crime analyst identified 52 incidents of suspected suicide in the years 2014 to 2019 where the police force responded to calls where a death or deaths had been discovered. A random sampling of twenty such incidents were identified for review:

Sudden Death Suicide 2014-2018 (13 selected)
Sudden Death Suicide 2019 (5 selected)
Sudden Death Non-Suicide of persons under the age of 50 (2 selected)

The focus on sudden death suicide investigations was deliberate since police response to such incidents are occasionally treated as non-criminal far too early in the police response to a potential crime scene. This can happen because of assumptions made by the person who reports the discovery of a dead body and the circumstances discovered by police on arrival to a scene that suggests a person has taken their own life, such as recovery of a suicide note, position of a body or absence of evidence of foul play. SJPF Human Death policy clearly states that "*All reported or discovered deaths will be treated as homicides until evidence to the contrary is established*".

Using the NBPC prepared guide and matrix, all twenty files were reviewed from start to finish with the assistance of SJPF member S/Sgt David Brooker. The guide examined twelve criteria that covered initial police response, scene supervision, coroner and medical examiner and if the sudden death fell into a certain category. Provincial policy on Human Deaths and SJPF policy identify those categories as sudden deaths anticipated at home, involving a child, aviation accidents, deaths onboard aircraft, industrial and peace officer involved fatalities. Only one of the reviewed incidents fell into a category and it was deemed non-suspicious.

Documentation and investigator articulation on the reviewed files met *Policing Standards* and in four of the incidents the files were noted as being exceptionally detailed. It is significant to note that all sudden death non-criminal incidents that are reported to the SJPF are attended to by both a supervisor and a member of the Forensic Identification Section. In every incident the scene was isolated and protected, photos/video were obtained, officer notes were adequate, major crime members attended or were consulted and next of kin notifications were looked after promptly. Autopsy and lab results were either in the file or noted.

There were some gaps discovered. In two of the incidents there were civilians unnecessarily near or in the scene and in one of the two incidents it was the attending coroner that allowed family members to view the body before police had fully completed their initial assessment. In one of the twenty files it was noted that a supervising Sergeant entered the room after a patrol officer had deemed an individual as deceased, but it was not articulated on the file the reason for the Sergeant to view the body. These noted occurrences were minor in nature and discussed with S/Sgt Brooker for follow up as the police force deemed necessary.

In five of the files, it was not articulated on the file if the deceased was subject of a CPIC query to determine if a criminal record existed. In cases where a deceased person has a criminal record the police are required to ensure a fingerprint is obtained and submitted to the national databank. The SJPF could quickly and effectively eliminate missing articulation in the operational file by creating and using a sudden death investigational check sheet.

Homicide file review

There were eleven homicide investigations that occurred in the years 2014 to 2019:

- 2014 (3)
- 2015 (3)
- 2016 (1)
- 2017 (1)
- 2018 (1)
- 2019 (2)

The review matrix created for SJPF was used to collect 49 points of data for analysis to identify standard operating procedures, best practices and gaps. The matrix categories were; incident details, assigned roles, initial response, command and control, crime scene management, use of forms, logs and checklists and offender outcomes. Four days of review were required to gather the data with the assistance of S/Sgt Sean Rocca. The NBPC reviewers interviewed two members of the MCU team that acted as file coordinators / lead investigators on two of the eleven files. One member of the SJPF Forensic Identification Section was also interviewed to gain an overview of crime scene investigative techniques and procedures used to maintain crime scene integrity.

At the time the review was completed, only one homicide remained under investigation. The case had a high probability of solvability with the SJPF edging closer to criminal charges. Overall, criminal charges had been successfully laid in eight of the eleven cases with five convictions and three cases

making their way through the court system. Two of the eleven cases involved domestic murder and suicide. Five of the murders were committed with an edged weapon, three involved a firearm and three were committed with physical force. Four of the victims were female and seven were male. All accused and suspected persons were male.

After the 2011 Oland investigation the SJPF created an electronic major incident template (Master Task List) to ensure that the significant amount of information generated from a murder investigation was effectively documented and organized for investigative task assignments, tracking of results, analysis and eventual disclosure to crown prosecutors. Using the SJPF Master Task List establishes a command triangle (SJPF MCU Business Rules) and assigns roles and responsibilities to investigators. The command triangle assignments typically occur immediately after the major crime unit is engaged. The SJPF electronic major incident template was used in all but three of the eleven incidents however this is not an indication that three of the investigations were improperly managed.

While the police force has major crime unit business rules, there are no standard operating procedures (policies) that specify when an investigation will formally establish the command triangle and populate the Master Task List which is foundational to MCM best practices. The absence of SJPF MCM policy in the event of a major incident such as a homicide is unacceptable.

In the materials provided to the NBPC by the SJPF, there were eleven forms reported as available for use in SJPF homicide investigation:

Continuity Record (crime scene, deceased, accused)
Scene Examination Checklist (source Canadian Police College)
Consideration for Special Forensic Services (source Canadian Police College)
Scene Walkthrough (source Canadian Police College)
SJPF Video Surveillance Canvas
SJPF Video Surveillance Log
Canvass Form (source Canadian Police College)
SJPF Canvass Tracking Log
SJPF Forensics Log
SJPF Suspect Elimination Log
SJPF Briefing Notes

It is important to note that in the absence of SJPF MCM policy for investigation of a major incident such as a homicide, there is no consistency in the use of the supplemental forms listed above. For example, the Canvass Tracking Log is not being used and the Canvass Form and Video Canvass Form are seldom used; however, there was evidence that canvassing of witnesses and video surveillance recordings were being completed and articulated within the narrative of the RMS. The Continuity Record (crime scene) was used at most of the eleven crime scenes. The Continuity Record (deceased) was used once. The Continuity Record (accused) was never used. The forms from the Canadian Police College MCM Manual (Scene examination, Special Forensic Services and Scene Walkthrough) were not on any file. The SJPF Forensic Log is not used however the FIS unit has a superior form. Briefings occurred in ten of the eleven cases, but the Briefing Notes form was used

only twice. In six of the ten cases either handwritten notes of the briefing were on file or a supplemental narrative on the file described the briefing outcomes.

Not using a specific form is not fatal nor necessarily detrimental to an investigation, however, the absence of consistency in documentation and use of investigational aids such as forms in a homicide investigation can be problematic for the file coordinator.

Crime scene management practices by the SJPF are strong and scenes were controlled quickly with perimeters established and maintained appropriately. Site access was controlled, and paths of contamination were considered and noted on the files. Judicial authorizations were obtained in every instance. Response by the Forensic Identification Section was fast and actions by the crime scene specialists were well documented. The SJPF crime analyst was engaged in nine of the eleven files and the time lines produced by the analyst were of exceptional quality. The SJPF victim liaison coordinator does a commendable job with assisting impacted family and friends.

Findings / conclusion

The overall outcomes of the SJPF homicide investigation speaks for itself; only one unsolved case which has a high probability of charges being laid and a 100% conviction rate on concluded investigations. Three cases are presently before the courts and the investigations were thoroughly and professionally conducted. The crime scene management issues raised by Justice Walsh at the conclusion of the first trial in 2015 have been adequately addressed by the SJPF.

Recommendations

1. That the Commission request that the Minister of Public Safety create provincial major case management policy.
2. That the Commission direct the Saint John Chief of Police to establish standard operating procedures/ policy for investigating major crime incidents.
3. That the Commission direct the Saint John Chief of Police to utilize a Sudden Death Checklist for supervisors to complete upon conclusion of a sudden death incident deemed as non-criminal in nature.

Jennifer Smith, Executive Director

Approved by:

Lynn Chaplin, Chair
Marc Léger, Vice-Chair
Bob Eckstein, Member
John Foran, Member