# A Method for Evaluating the Adequacy of Police and Coroner Investigations into Suspicious Unnatural Deaths

*Ted Palys[1], annie ross[2], Steff King[3] & Gail S. Anderson[4]*

**Abstract**

Canada has witnessed thousands of Indigenous testimonies about the suspicious deaths and disappearances of their loved ones and the deficient or non-existent investigations thereafter. Despite growing attention to Indigenous deaths in inquiries and government apologies, there remains little information at ground level for families on how to challenge investigative practices and few cases that have done so successfully. Our research began when we were invited to evaluate the investigations into the suspicious deaths of three Indigenous youth in Canada. We did so by first generating a generic list of ostensibly "standard" investigative principles and procedures and then using that list to evaluate police and coroner behaviour in those cases. Results revealed numerous instances of inadequacy where investigators either did not perform the required procedure(s) or did not complete tasks to nationally and internationally recognized standards; police and the coroner performed half or fewer of the "required" procedures in each of the three cases. We include the checklist here for other families and communities to use to assess other investigations into questionable deaths that occur in their communities and press for accountability. We conclude with a discussion of the strengths and limitations of that approach.

**Keywords:** Indigenous, death investigation, police misconduct, medico-legal, standard investigative practice

[1] Simon Fraser University, Canada
[2] Simon Fraser University, Canada
[3] Simon Fraser University, Canada
[4] Simon Fraser University, Canada

**Acknowledgement:** First and foremost, we thank the families of the deceased for allowing us into their lives and sharing their experiences; we have aspired from the beginning to earn and maintain their trust. We also thank Grand Chief Stewart Phillip of the Union of BC Indian Chiefs, for his support for the families prior to our involvement, and for his and their encouragement and support thereafter. Thanks are also due to the BC Civil Liberties Association, and especially former legal advisor Micheal Vonn, for their early involvement in this project and for sharing the information they compiled. Finally, we are grateful for funding from SFU's "Community engagement initiative" that allowed for site visits and will be used to fund a memorial to commemorate the three deceased, and for the comments of two anonymous reviewers.

## Introduction

While scholars such as Tauri (2014) characterize settler justice systems more generally as part of the colonial grind that keeps Indigenous communities marginalized, criminalized and focused on survival, the police, as first responders, are often the first glimpse many Indigenous people and communities get of their state's justice system. Police responsibility includes investigations into Indigenous deaths (Smiles, 2018), which gives them enormous discretion over the process as well as its outcomes. Investigative bodies retain the power to act, or not act, in any case, affording no control to surviving families on how the death is addressed. This makes death investigation a crucial site for assessing systemic bias (Hylton, 2012; Tyson, 2003).

The experience of inadequate Indigenous death investigations is one that has been shared by countless Indigenous families across Canada. In Thunder Bay, Ontario, nine Indigenous families were engaged in a critical review of the investigations into the suspicious deaths of their children, which investigators initially dismissed as accidents or suicides (Johnstone & Lee, 2022; Talaga, 2017). In Vancouver, B.C. there have been numerous public gatherings and protests in response to the lack of attention from municipal and federal police regarding local Missing and Murdered Indigenous Women, Girls, and Two-spirit people (Deer, 2022; Garrett, 2023; Mandes, 2022; St. Denis 2023a, 2023b). Between May 2017 and October 2018, over 2,380 Indigenous families came forward before the Canadian government to give testimonies about the incomplete or non-existent investigations into the disappearance or deaths of their loved ones (Lheidli

T'enneh First Nation et al., 2006; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). Their testimonies paint a consistent and concerning picture in which Indigenous families struggle to get investigators to take the disappearances and deaths of their loved ones seriously.

Outraged families and concerned advocates point to a notable lack of transparency about the investigative practices to which all cases are entitled. Their narratives speak to frequent dismissal of suspicious deaths as accidents or suicide, regular failure to collect and analyze evidence, and disregard for collecting witness or family statements; all of which violate standard investigative procedures (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2017; Lheidli T'enneh First Nation et al., 2006).

Nor is the phenomenon unique to Canada. American Native communities baulk at the rising number of murdered Indigenous cases in the United States (Goodyear, 2019). Aboriginal and Torres Strait Islander families cry out at how many family members continue to die in Australian police custody (Allam, 2021; Royal Commission into Aboriginal Deaths in Custody, 1991; Tsirtsakis, 2021; Whittaker, 2021). Māori communities repeatedly remind the New Zealand government that coroners snatch their loved ones' organs, tissue, and bodies before their souls can pass on (Selket et al., 2015). The disproportionate number of Indigenous deaths dismissed as suicides, across multiple countries, remains unacknowledged by many State institutions (Carpenter et al., 2021). The United Nations has taken notice. Over the past decade, both the UN's Expert Mechanism on the Rights of Indigenous Peoples and the Human Rights Council have voiced concern about repeated failures to investigate and implement new strategies to reduce MMIP cases in each country (Goad, 2020; Narine, 2012).

It is vital that investigator conduct is held to account and that families and communities have the resources with which to assess case adequacy. Police and medico-legal standard procedures do outline specific investigative steps that should be conducted in every case involving suspicious death, but these resources are restricted to the public. Although withholding standard procedures may conceal investigative tactics from prospective perpetrators, it also prevents the public from understanding, or challenging, investigator conduct. Amidst the many communities and thousands of Indigenous families with concerns over inadequate death investigations, there is an

immediate need for publicly accessible death investigation assessment criteria.

We developed such an instrument as a way to assess the adequacy of police investigations into the deaths of three Indigenous youth in Prince Rupert, British Columbia, Canada, a small community of 12,300 people located in the territory of the Ts'msyen Nation. All three died unnatural deaths in suspicious circumstances. Their families believed that investigators did not give each case its due regard. A wealth of information compiled about these cases by family members and concerned advocates – including interviews with police and family members, media reports around the times of the deaths, reports from a private investigator, coroner reports and other archival information – provided a rare opportunity for a fine-grained analysis into how the investigations were conducted and the impacts these had on the families.

Our primary research question involved assessing how adequately the three Indigenous death investigations in Prince Rupert were conducted when compared with what is represented in the policing literature as "standard investigative procedures."

We begin the next section by explaining the background of the three cases, and the various people who brought us to this evaluation. We then outline the assessment framework we generated as a minimal set of criteria based on provincial, national and international standards of police and forensic investigation, which were then applied to the three RCMP investigations in Prince Rupert.

**Background**

The deaths of 13-year-old Kayla Rose McKay, 16-year-old Emmalee McLean and 21-year-old Justin Brooks (see Perry 2013a, 2013b; Thomas, 2014) received much attention from the Indigenous community, and very little from the RCMP, the policing authority under whose jurisdiction Prince Rupert falls. All three were found deceased near the waterfront in Prince Rupert. Kayla disappeared after attending a party with her friends in 2004 (King, 2021). Her body was discovered three days later next to an unconscious young man near the Prince Rupert waterfront. A post-mortem examination revealed alcohol in her system and indications of sexual assault. In 2010, Emmalee also was last seen alive at a party with friends; her body was discovered the next day partially submerged at the waterfront. Hospital staff noted suspicious bruising on her body and toxicological analyses showed

acute alcohol intoxication. In 2013, Justin spent the evening at the waterfront with a few friends, reportedly getting into a fight with one of them. His friends claimed he was alive when they last saw him that night. A local resident discovered his body in the water early the next morning. His post-mortem records also identified noticeable bruising, blunt force trauma, and acute alcohol intoxication.

Despite each person dying unnatural deaths under suspicious circumstances, investigators quickly labelled them as "suicide" or "accident," with the consequence that no one would ever be charged. Concerned with this pattern of death and dismissal, members of a local Indigenous justice program contacted the Executive Director of the Vancouver Aboriginal Transformative Justice Services Society (VATJSS), Christine Martin, asking her to come as an independent observer to assess the situation and ideally promote further investigation into the cases.

Ms Martin later would ask Micheal Vonn, then legal advisor to the B.C. Civil Liberties Association (BCCLA), and Grand Chief Stewart Phillip of the Union of B.C. Indian Chiefs (UBCIC), to join her on a site visit and interview family members (Perry, 2013a). Members of the local RCMP detachment and local Coroner's Office also were interviewed. They insisted that all was done properly, which was quite in contrast to observations by Grand Chief Phillip, who stated, "The RCMP were very indifferent and negligent in their investigations into the passings of these three young people" (Perry, 2013b, para.3). Members of the families pointed to numerous inconsistencies between RCMP statements, the autopsy report, and obvious facts of the case (Perry, 2013b; Thomas, 2014).

Two years later, with the families still seeking justice and answers from the RCMP, Ms. Martin would approach Ted Palys of Simon Fraser University's School of Criminology, who was joined by colleague annie ross of SFU's Department of Indigenous Studies. Palys did his own site visit that involved meeting and listening to the families in 2016 thanks to SFU funding to Palys and ross for a "Community engagement" initiative. The two subsequently would involve SFU colleague Gail Anderson, a forensic expert, and Steff King, who at that time was an MA student looking for a thesis topic.

**Method**

Our approach involved comparing the RCMP and Coroner's actual conduct in the investigation to ostensibly "standard" death investigative procedures. This method is commonly employed in traditional judicial inquiries of

investigative adequacy by comparing investigative conduct to a standard practice baseline (Civilian Review and Complaints Commission, 2021).

### *Developing a Standard Investigative Checklist*

Because police agencies do not share such information, we first needed to create a checklist of standard steps beginning at the moment a body is found and its existence reported to police, to the conclusion of the investigation. Canadian national and provincial resources included policies specific to human rights and/or police or coroner practices. Policies examined included the *Canadian Victims Bill of Rights* (2015), the *RCMP Act* (1985), the BC *Police Act* (1996), the BC *Coroners Act* (2007), and the BC *Provincial Policing Standards* (British Columbia, 2020). International investigative standards came from the United Nations Office of the High Commissioner for Human Rights (2017)[i] in a policy document titled *The Minnesota Protocol on the Investigation of Potentially Unlawful Death.* This document summarizes the minimum procedures required for death investigators working in UN countries. Standard practices outlined in these policies are minimal and mandatory for investigators to ensure the evidence they gather is both comprehensive and untainted to maximize the likelihood of identifying and convicting the actual perpetrator.

Official recommendation reports and academic texts were used to fill in procedural gaps. Death investigation procedure recommendation reports came from the National Medico-legal Review Panel (NMRP) in the United States (National Institute of Justice US et al., 2011). Two editions of this resource included minimum standards agreed upon by death investigation practitioners across the states as well as support from government organizations including the US Department of Justice, the National Institute of Justice, the Centers for Disease Control and Prevention, and the Bureau of Justice Assistance. Academic texts included Maloney's (2018) *Death Scene Investigation: Procedural Guide*, Geberth's (2014) *Practical Homicide Investigation Checklist and Field Guide* and *Practical Homicide Investigation: Tactics, Procedures, and Forensic Techniques* (Geberth, 2015), Fisher and Fisher's (2012) *Techniques of Crime Scene Investigation*, and Watkins, Anderson, Bulmer, and Rondinelli's (2019) *Evidence and Investigation: From the Crime Scene to the Courtroom*. These resources teach new academics and practitioners basic death investigation procedures. Standard practices pulled from both recommendation reports and academic texts had to appear across multiple texts, affirming their reliability and status as indeed

"standard." The complete inventory, which involved 43 different dimensions that potentially could be involved in a given case, appears in Table 1.

***Table 1. Standard Procedures for Death Investigations.***

| Initial report intake |
|---|
| 1. Report taken seriously: no delay in response and record of report |
| 2. Reportee informed to stay off scene and prevent others from entering |
| 3. Missing Persons Report: immediate response and risk assessment |
| **Arriving at and securing the scene** |
| 4. Section off and secure crime scene |
| 5. Document original scene contexts |
| 6. Prevent civilians from entering the scene |
| 7. Request professional investigators to attend the scene |
| **Documenting and evaluating the scene** |
| 8. Assumption of homicide until proven otherwise; investigate to prosecution standards |
| 9. Establish lead investigator; record professionals on scene and their conduct |
| 10. Investigator walkthrough and extensive note-taking of scene context for later record |
| **Evidence collection and management** |
| 11. Develop evidence processing plan; collect and evaluate all relevant items |
| 12. Specialized evidence collection, if necessary |
| 13. Establish evidence steward facility; housing for future evaluation and/or litigation; plan for return to families upon case closure |
| 14. Forensic analysis of evidence to independent laboratory (assume evidence timeline) |
| 15. Establish additional search plans for missing items |
| **Witness interviews and canvassing** |
| 16. Interview suspects present at the scene: evaluate demeanour and include signed documentation |
| 17. Canvass the area surrounding scenes; interview potential witnesses |
| 18. Interview decedent's personal community and family for personal history |
| **Documenting and evaluating the body** |
| 19. Coroner has control of the body; only professional who may authorize removal or altering |
| 20. Preliminary external examination of the body on scene; documentation of original context |
| 21. Medico-legal professional must examine the body before investigators establish manner of death |
| 22. Identification efforts conducted |
| 23. Autopsy off-scene required for suspicious or unnatural deaths; family informed |

| |
|---|
| 24. Investigators present at autopsy/body examination |
| 25. Coroner's report uses accessible language and includes all findings from body examination; include explanation/ communication of injuries and findings |
| 26. Coroner may order additional applicable tests for examination |
| 27. Coroner may recommend for official inquiry (required for minors) |
| Supporting the surviving families |
| 28. Death notification in-person: provide brief details and investigator contact information |
| 29. Investigators should discuss confirming evidence and answer questions |
| 30. Families informed of autopsy if applicable |
| 31. Family selects representative to identify the body |
| 32. Families provided support resources and liaisons; police must communicate with liaisons |
| 33. Medico-legals must provide a copy of the coroner's report and contact information for later questions |
| 34. Family provided access to basic investigation information and progress |
| 35. Case referred to cold case unit if unsolved for a prolonged period without progress |
| 36. Cold case investigators maintain five cases maximum at a time |
| 37. Establish routine protocol for investigation and repeat review of new forensic techniques and personnel progress |
| Checks and balances |
| 38. Investigators required to follow all procedural conduct outlined in policing standards |
| 39. Small agencies must establish standard procedures for investigators and make them publicly accessible |
| 40. Directors should review investigator conduct and compliance routinely and act on any reports of inadequacy |
| 41. Chief Coroner may order reinvestigation for inadequate case conduct and alter cause of death determinations as necessary; May order inquest for inconsistent cases; Forensic doctors must act independently |
| 42. Civilians may file official complaints for review |
| 43. Investigators are transparent; investigative procedures and outcome provided to public and families |

### *Data Sources as to Police Practice*

Investigation context data for the three cases included five semi-structured interviews and a variety of case documents. Three interviews were conducted in Prince Rupert by Palys with the families of Kayla McKay, Emmalee McLean, and Justin Brooks. He was introduced and accompanied by Christine Martin of VATJSS as a family advocate and support. Each interview involved a conversational, supportive, environment with no

preordained structure. Families were simply asked to recount the context before and after their children's deaths and the conduct of each investigation/interaction with investigators thereafter. These were in addition to the two interviews that had been conducted previously by Ms Martin and Micheal Vonn of BCCLA about the process of negotiating with investigators for information.

Interview information was triangulated with conversation records between families, law enforcement, and the local coroner as well as official case documentation (e.g., coroner's reports) that were finally provided to the families through Freedom of Information requests. The BCCLA legal advisor also contributed a legal review of each case for additional context based on her observations and discussions with both families and police during the 2013 site visit. Other documentation included (1) an email from the Superintendent Operations Officer in the E Division Major Crime Section to Dr. Evan Adams, Deputy Chief Medical Officer for BC's First Nations Health Authority regarding their review of the investigation into the death of Justin Brooks; and (2) a report from Dolo Investigations, a private investigation firm hired by the family of Justin Brooks eight months after his death to discover and pursue any leads that had not been pursued by police. All documentation was either publicly available (e.g., news reports) or was shared with us by permission of the families.

### *Ethical Considerations*

The study involved severely traumatic events for the three families and their community. The priority was thus to protect the well-being of the families by ensuring open communication throughout, and after, the research process. The research goal was always intended for the benefit of those impacted by inadequate investigations and thus reflected a community collaboration to achieve that goal.

Family interviews required special care and openness given the sensitive nature of discussing the deaths of their children (Cowles, 1988). The research team emphasized open communication with the families prior to each interview about the intentions of the research, confidentiality options, and informed consent. A support advocate who had an established relationship with the family prior to our involvement was present during each interview.

Given that the analysis involved a critical review of institutions in power (i.e., the RCMP and BC Coroners Service), concerns arose about how

study data that contained identifying information might place the families at risk of harm. Accordingly, the research team worked with the families to determine how data would be presented in the results, with the families preferring to use given names and locations openly.

### *Data analysis*

Case analyses involved comparing investigative conduct to what the literature outlines as "standard procedure" for each dimension of each case, and then calculating a total investigative adequacy score that reflected the proportion of relevant requirements that were actually completed (i.e., number of adequate procedures performed divided by the total number of relevant items). We allowed three possible outcomes for each investigative component: the individual procedure was either (1) conducted adequately; (2) conducted partially or inadequately; or (3) not applicable.[ii]

## Results

The procedural inadequacies in the investigations of the deaths of Kayla McKay, Emmalee McLean, and Justin Brooks were numerous. Table 2 shows the aggregate adequacy scores for each case – all three of which involved police conducting half or fewer of the standard investigative procedures ostensibly *required* in such cases.[iii]

***Table 2. Investigative Conduct Adequacy Indices for Each Case.***

| | Kayla McKay | Emmalee McLean | Justin Brooks |
|---|---|---|---|
| Minimal Standard Met | 12 | 11 | 19 |
| Failure to Meet Minimal Standard | 12 | 15 | 20 |
| Total Number of Relevant Actions | 24 | 26 | 39 |
| Investigative Adequacy Index (Adequate/Total x 100) | 50% | 42% | 49% |

### *Evidence Collection*

Evidence-collection procedures involve strict requirements to support investigative conclusions and potential court outcomes. Failure to conduct proper evidence collection and analysis thus may contribute to investigative failures and false conclusions (Watkins et al., 2019) and are cited by Rossmo (2009) as two of the main reasons for both investigative failure and wrongful

conviction. Evidentiary information is easily lost and cannot be recovered if missed in the early phases of the investigation.

In each of the Prince Rupert cases, investigators initiated the standard procedure by collecting a few meaningful items. In Kayla's case, investigators requested material from her home for a DNA comparison of her toothbrush and her grandmother's hairbrush. For Emmalee, surveillance footage from a local convenience store was collected and her clothing was inventoried. Justin's belongings, including his discarded clothing, keys, wallet, and iPod were retrieved from the scene. Although the collection of these items demonstrated some regard for standard evidence collection, investigators failed to complete a thorough collection sweep, forensic analysis, and return process.

Neither Kayla's nor Emmalee's family ever received their personal belongings back from investigators, even after the cases had long been closed. The standard procedure requires that investigators handle and process evidence with the mindset that they will be returned to the next of kin once all relevant information has been retrieved and the case is officially closed (Geberth, 2015; National Institute of Justice US et al., 2011). This allows evidence storage facilities to remain clear for new case materials in the future, while also affording families an opportunity for closure. By not returning Kayla's belongings, particularly her clothing, to her grandparents, the police left a lasting sense of disbelief that the deceased was actually their granddaughter. Neither grandparent had been allowed to view Kayla's body after her death as police denied their request to identify her at the morgue and her funeral had a closed-casket ceremony. After ten years, Kayla's grandfather reflected: "We don't even know if that was her clothes that they have."

In Justin's case, investigators demonstrated a lack of diligence to collect all vital evidence at the scene and failed to conduct forensic analyses of the items they retrieved. Justin's family described many instances where investigators failed, or outright refused, to collect relevant materials and information. For example, after six months of inactivity in the case, the family hired a Private Investigator to search for information. The PI quickly learned that police had failed to collect surveillance footage from a convenience store where witnesses stated Justin had been on the night of his death. Justin's mother recounted that when the PI attempted to retrieve the footage thereafter, the store clerk said "No we don't have it. The RCMP came in yesterday and took it." It appeared to the local community that the

police had only collected the footage once the PI began their investigation, instead of on the numerous occasions over the first six months the family had asked the police to collect it. Additional concern arose when investigators disregarded witness statements concerning text messages and some of Justin's missing personal belongings. Common police responses to evidence collection requests were that they would get to it eventually. What investigators failed to consider is that negligence to collect and preserve evidence might actually constitute abuse of process provided that vital evidence could have contributed to case outcomes (*R v Stinchcombe,* 1991; Watkins et al., 2019).

For the evidence investigators did collect in Justin's case, proper analyses were not conducted. Justin's clothing, which had blood stains from an altercation he had been in the night of his death, was returned to his family the day after he was found, without any analysis of whose blood was spilt. Since Justin's case was still open on the second day, returning his clothing to the family violated standard practice. Procedural guidelines require continuous protection and management of evidence through the duration of a case, primarily for the purpose of future legal evaluation and litigation (Geberth, 2015; National Institute of Justice US et al., 2011). In addition, forensic analyses take time (Watkins et al., 2019). Forensic centres are few and far between in Canada, thus requiring lengthy shipping periods to certified labs and backlogged wait periods for results outside of investigator control. The reality that Justin's bloodied clothing would have received thorough forensic analysis within a day of collection is unlikely; what evidence was missed that could have been helpful to contextualize the case?

The importance of proper evidence collection and analysis is reflected in the quality of case outcomes. For example, both Kayla and Emmalee's cases involved identified prime suspects associated with their deaths. Each case proceeded to the Crown Council by recommendation of Criminal Negligence, yet the Crown advised that there was "no substantial likelihood of conviction" given the lack of evidence. Serious concerns arose from the families and their advocacy team that the lack of evidence was a product of the investigator's inadequate evidence-collection methods.

### *Communication, Interviews, and Canvassing*

Many people were with Kayla, Emmalee, and Justin on the nights of their deaths. These people, as well as potential onlookers from the housing units situated at the waterfront, made ideal witnesses for police to interview. In Kayla and Emmalee's cases, police investigators interviewed attendees at each party and identified key suspects. However, investigators failed to follow up with either person of interest for questioning, allowing both to flee Prince Rupert. In both cases, the families reported that suspects left town very soon after they were identified, and police seemed uninterested in tracking them down for information. Emmalee's aunt commented: "I'm not sure if they got a hold of him or even talked to him and they apparently talked to everybody else …that I know of… but for him, he was gone." Local police should have followed up with the detachment in the suspect's new jurisdiction. Major Case Management (MCM) procedure provided in the British Columbia (2020) Provincial Policing Standards requires communication across policing jurisdictions so that case investigations do not miss out on vital information as people of interest move.

In Justin's case, police interviews of his friends, who were with him the night of his death, were only a small portion of the interviews and canvassing required. Investigative practice training tools (Geberth, 2015; Maloney, 2018) and UN Human Rights policy (United Nations Office of the High Commissioner on Human Rights, 2017) both affirm that investigators need to canvass areas near both primary and ancillary scenes. In Prince Rupert, investigators failed to interview local residents who lived near the scene. Rather, it was Justin's family who went door-to-door asking for information. Justin's mother reflected on a conversation she had with one resident who had never been questioned despite having windows that faced the crime scene: "We asked her if the cops been by talking to people and she said 'No, nobody… You're the first ones.'"

Additional witness information was lost when investigators refused to collect statements from concerned residents. International standards from the United Nations Office of the High Commissioner on Human Rights (2017) require investigators to allow any person to submit statements which they feel may be relevant to a case. Justin's family received phone calls from two potential witnesses who said they were told by police that their statements were not needed. Justin's mother recalled:

> *I know of another lady that phoned in trying to help out and she … actually found me in [town] late at night 'cause it was really bothering her. She said, 'I tried phoning the CrimeStoppers line but they didn't want to take my information because they said there was no foul play.*

Quick and undoubtedly premature determinations of each case's outcome, such as 'no foul play,' inhibited much of the information collection procedures required. The standard procedure outlines that interview information should not only come from potential witnesses but also from decedents' families (National Institute of Justice US et al., 2011; United Nations Office of the High Commissioner on Human Rights, 2017). Investigators are required to interview personal communities and family for a decedent profile and history, as information from these interviews provides context to the scene and can help generate and evaluate investigator theories of what happened. In both Emmalee and Justin's cases, investigators quickly concluded case outcomes of 'accidental drowning' and 'suicide by drowning,' yet never interviewed the families who would have told them that both young people had severe fears of going near the water.

### *Evaluating the Body*

A coroner's role is to speak for the dead. The BC Coroners Act (2007) requires a coroner's presence at the scene of any unnatural or unexpected death – including the sudden deaths of young people – a policy the local coroner followed in each case. The coroner ordered autopsies for Kayla, Emmalee, and Justin in Vancouver, and appropriately consulted with police for scene context (Fisher & Fisher, 2012; Maloney, 2018; Watkins et al., 2019; United Nations Office of the High Commissioner on Human Rights, 2017). Additional tests were scheduled, including sexual assault assessments for Kayla and Emmalee, and toxicological analyses for all three cases. The information collected in each of these procedural steps would provide the coroner with context for their final determination, a summary of which is required to appear in a final report (United Nations Office of the High Commissioner on Human Rights, 2017).

Standard investigative guidelines also emphasize the duty of the coroner to communicate with families about both the procedures they conducted and their conclusions using accessible language (Geberth, 2015). The three families met with mixed responses according to this standard.

Kayla's grandparents reflected that they heard very little from the coroner at first, leaving the onus on them to reach out for information. Kayla's grandfather noted: "I finally got a hold of them and I was talking to them and I thought they were still investigating and he said, 'Well, didn't they tell you?' I said, 'Tell me what?' He said, 'Well, we ruled it, she died of alcohol poisoning.'" The information came as a sudden surprise. The family had not received an explanation for what procedures were conducted, nor information on how the conclusion was determined or what it meant in relation to the manner of death. Instead of receiving a copy of the coroner's report, their only information was that the case had been closed a while before they had heard anything from investigators.

Emmalee's aunt had a more positive experience communicating with the coroner. In the years following the investigation, she said that the coroner contacted her a few times "to ask questions or to tell me that they're still looking into it and that they haven't forgotten." While the coroner did explain their conclusions and summarized their report to Emmalee's aunt over the phone, it took the coroner's service a year and a half to send the final report. When it finally did arrive, the family noted that it never explained the suspicious bruising that Emmalee had on her body when found. Regardless of the final determination of death, the United Nations Office of the High Commissioner on Human Rights (2017) still requires that medico-legal investigators provide their opinion on the presence or possible cause of injuries in their final report.

Justin's family experienced similar frustrations. The family received the coroner's report in the mail, yet never received a phone call from the coroner to explain their findings. One of the family's legal advocates commented: "So that's how the coroner let them know … sticking a report in the mail. No contact behind it. No opportunity to ask any questions." And questions they had. In the mailed report, the coroner succinctly summarized the autopsy findings - findings that helped change the police's initial determination of 'suicide' to 'accidental' – yet paid little attention to his blunt force injuries and provided no clear explanation for the cause and manner of death determination. This distinction between the 'cause' and the 'manner' of death is an important one. For Kayla, Emmalee, and Justin, the causes of their deaths may have been straightforward from a medical perspective, but it was the manner of deaths that required greater attention and explanation from the coroner with the families.

The families and their advocacy teams also wondered why there were no inquests into the deaths of minors. The BC Coroners Act (2007) requires that the Chief Coroner request a Coroner Service Inquest for unnatural death, particularly for children under the age of 18. Kayla and Emmalee were 13 and 16 years old, respectively, and had significant amounts of alcohol in their systems when they died – and Kayla's post-mortem examination further showed evidence of sexual assault – yet neither case went under review for crimes against a minor. Justin's family also notes that the individuals who beat him the night of his death were never brought under legal scrutiny, nor did that information factor into his investigation.

### *Supporting the Families*

Death investigation standard practices reserve room for family support procedures given the devasting circumstances they address. Procedures identify what resources, information, and opportunities investigators need to offer to surviving families to promote their confidence in the investigation and promote healing during the grieving process. The Canadian Victims Bill of Rights (2015) affirms that families have the right to information about support services and programs, criminal justice procedures, and how to file a complaint. However, only Kayla and Emmalee's families received victim services liaisons during the initial death notification. For Justin's family, the early police determination of "suicide" and "accidental" appeared to have affected their access to victim services. Their legal advocate later commented, "I asked her [Justin's mother] about victim services. 'Did they come over?… What part did they play in it?' And she said they didn't contact them at all." Even days after Justin's death, his mother reflected that no one from the investigation had attempted to contact them at all: "I had no phone call from anybody… I was just left … sitting there dealing with it myself." Undeterred by the silence, Justin's mother went on to contact investigators searching for answers and eventually hired her own private investigator when local police refused to communicate.

Families have "the right to seek and obtain information on the causes of a killing and to learn the truth about the circumstances, events and causes that led to it" (United Nations Office of the High Commissioner on Human Rights, 2017, p. 4). Limited communication between investigators and the families was a consistent problem across all three cases. Kayla's grandmother revealed that investigators waited two years after the case was officially closed to speak with them about the investigation.

Emmalee and Justin's families gave very similar accounts that investigators typically avoided giving them information about the cases. When the families asked questions directly, they were almost always refused comment. Both international and BC investigative policies emphasize the importance of communicating with families throughout and after an investigation. Policies advise regular updates with family representatives in which they "must be kept appropriately informed of the progress of an investigation, and treated with compassion and respect" (British Columbia, 2020, p. 127).

While lacking victim services and investigator silence demonstrate clear inattention to support procedures, the refusal to allow the families to identify Kayla and Justin's bodies had a chilling impact on their families' well-being. Geberth (2015) asserts that standard practices should allow for families to select a representative to identify the body at the morgue. Members of both Kayla and Justin's families asked investigators if they could see their children at the morgue, but their requests were denied. As Justin's mother recounted, "I was practically begging [the coroner] to go see him… I wanted to know if it was my son or not… we don't even know if it's him." Kayla's grandfather expressed the same disbelief that it was his granddaughter who the police had found at the waterfront. The difference for Kayla's family was that they never got to see her body again after the last night they saw her alive.

> *What made it really hard for us was even though she was in the casket, in the memorial and the funeral, in our minds and our hearts [was] 'is that really her?' That's why, after the funeral,… we went and looked around to try and see if we could find her. See if we could find her walk[ing] around. Maybe that wasn't her... That's how hurt we were because of how things were handled, you know. Back from the beginning… I wasn't happy [with] the way they [investigators] handled it.* (Kayla McKay's grandfather)

Fighting for investigative information and support is a difficult and emotionally taxing process for families – one they should not have to engage in. Providing the opportunity for family identification fulfils investigative requirements while also providing confirmation to families that it is indeed their loved one who has left this world.

**Discussion**

We began this research seeking to evaluate how adequately three Indigenous death investigations in Prince Rupert were conducted when compared with what provincial, national and international sources identify as "standard investigative procedures." We conclude that RCMP investigators did not fulfill their duty in those cases. Local officers and the coroner did fulfill some requirements, but the few investigative procedures adequately conducted were greatly overshadowed by all those that were not performed to standard or at all.

The justice system failed Kayla, Emmalee, and Justin's families. Not only were they denied a full investigation, but there was also no regard or respect for their unique cultural beliefs and needs. It is a hard pill to swallow to know that they are not the only families who have been failed in that regard as well. While it might be tempting to dismiss the experience of the three families whose loss we document here to inexperienced investigators working in a small detachment in rural British Columbia, inadequate Indigenous death investigations are a problem that exists well past Prince Rupert and are instead an international issue to be addressed. Certainly, our findings are consistent with authors such as Comack (2012), whose *Racialized Policing* sees police practice reaffirming a colonial order that reminds Indigenous people of their second-class status. Our analysis is just one fine-grained look at the injustices that add up, one by one, to create a huge international problem.

We hope that the checklist we developed will help individuals and communities who find themselves in similar situations to the families who guided our research by reducing ambiguity about whether investigators have done all they should have. But it is no panacea. As one anonymous reviewer reminded us, our analysis and immense literature regarding murdered and missing Indigenous people reaffirm that what are supposed to be "standard investigative procedures" have not been so "standard" when it comes to the deaths of Indigenous people. "Police discretion" becomes systemic racism when racist tropes replace and even preclude investigative rigor by re-defining effort as a waste of time. The families who guided our research were not passive individuals accepting what they were told. They repeatedly expressed concern to police and the coroner about what should have been obvious questions about whether witnesses were interviewed, whether blood stains were analyzed, and why prime suspects were allowed to disappear

with no follow-up. An Indigenous family or community holding up a list of investigative "shoulds" and "musts," even when that list has the acquired credibility of appearing in a peer-reviewed journal, still can be ignored (McDiarmid, 2019; Razack, 2015, 2020).

Even though the Canadian government has released numerous inquiries on MMIP, and investigative bodies have launched specialized investigative task forces, testimonies continue to increase about the inadequacies of Indigenous death investigations (Michalko, 2016; Native Women's Association of Canada, 2020). Kayla, Emmalee, and Justin's cases demonstrate that greater efforts are needed to see effective change for similar investigations. Mechanisms and structures that ensure transparency and accountability would give families and communities a place to turn to when their questions and concerns are not addressed.

Several recommendations from the National Inquiry into missing and murdered Indigenous Women and Girls speak to that possibility. Recommendation 1.7, for example, encourages the creation of a National Indigenous and Human Rights Ombudsperson that is adequately funded and politically independent. Recommendation 5.7 encourages the creation of civilian advisory and oversight bodies at more local levels, and (1) that ensures membership includes representation of Indigenous women, girls, and 2SLGBTQQIA people, inclusive of diverse Indigenous cultural backgrounds; (2) that they have the power to observe and oversee investigations in relation to police negligence or misconduct in any cases involving Indigenous people; and (3) publicly report on police progress in addressing findings and recommendations on at least an annual basis. Any such office must have the power not only to review investigative conduct, but also to demand answers from investigators.

We also need to view these issues in light of broader standards and rights of self-determination that are beginning to be recognized both internationally and in some state jurisdictions, Canada being one of them (United Nations, 2007; McGruder, 2022; Narine, 2012; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2017; Truth and Reconciliation Commission of Canada, 2015). The relationship between police and Indigenous Peoples has always been a tense one; police were and continue to be the ones on the ground responsible for implementing imposed colonial legal orders. International human rights standards such as the UN Declaration on the Rights of Indigenous Peoples reaffirm the rights of Indigenous Peoples to self-determination and encourage respect for

Indigenous institutions and legal structures. The form of policing that a People wants to adopt, if at all, is one of those elements to be considered.

Although we have focused on the police in this article, it is not only on investigators to find a solution. Rather, the onus is on government officials, police, medico-legal practitioners, human rights advocates, academics, and the public, with participation by Indigenous community members and their first-hand experience-based testimony that is valued. There are many next steps to take within each realm, and, so far, the Indigenous community has taken on too much of the burden alone. Our collective and individual actions should reflect that of Kayla McKay's grandfather, who graciously looks beyond his own terrible loss to think of the implications for others:

> *We know, and we hope and pray, that it'll get somewhere. Not for our own good, but for [other people too]…[For] everybody else that's going to be going through this in the near future… that it's not going to be just swept under the rug too.*

We share his hope, and to that end offer this analysis and the investigative standards we have outlined to other families and communities to hold justice system personnel – and especially police and coroners -- to account. Others who experience the heartbreak of the loss of their children and grandchildren should not have it compounded by investigators whose behaviour exemplifies the systemic racism that Indigenous People/s encounter every day and that only some police and politicians are starting to acknowledge exists (e.g., see Breen, 2020; Morin, 2020).

**References**

Allam, L. (2021, December 6). 'Beyond heartbreaking': 500 Indigenous deaths in custody since 1991 Royal Commission. *The Guardian*. https://www.theguardian.com/australia-news/2021/dec/06/beyond-heartbreaking-500-indigenous-deaths-in-custody-since-1991-royal-commission

Breen, K. (2020, June 12). Systemic racism exists in RCMP, commissioner admits after backlash. *Global News*. https://globalnews.ca/news/7060822/rcmp-commissioner-systemic-racism/

British Columbia. (2020). *Provincial policing standards*. https://www2.gov.bc.ca/gov/content/justice/criminal-justice/policing-in-bc/policing-standards

Carpenter, B., Harris, M., Jowett, S., Tait, G., & Bray, R. S. (2021). Coronial inquests, Indigenous suicide and the colonial narrative. *Critical Criminology*, *29*, 527–545.

Civilian Review and Complaints Commission. (2021). *Chairperson-initiated complaint and public investigation into the RCMP's investigation of the death of Colten Boushie and the events that followed.* https://www.crcc-ccetp.gc.ca/pdf/boushie-rep-en.pdf.

Comack, E. (2012). *Racialized policing: Aboriginal people's encounters with the police*. Fernwood Publishing.

Cowles, K. V. (1988). Issues in qualitative research on sensitive topics. *Western Journal of Nursing Research, 10* (2), 163–179.

Deer, K. (2022, October 3). Families of MMIWG say police neglected, mishandled investigations into their cases. *CBC News*. https://www.cbc.ca/news/indigenous/mmiwg-vigil-poorman-osoup-harrison-wilson-1.6604705

Fisher, B. A. J., & Fisher, D. R. (2012). *Techniques of crime scene investigation*. (8th ed). CRC Press.

Garrett, C. (2023, February 27). Families call out Vancouver police over investigations into three Indigenous deaths. *Global News*. https://globalnews.ca/news/9515679/families-call-out-vancouver-police-over-indigenous-investigations/

Geberth, V. J. (2014). *Practical homicide investigation checklist and field guide*. CRC Press.

Geberth, V. J. (2015). *Practical homicide investigation: Tactics, procedures, and forensic techniques*. (5th ed.) CRC Press.

Goad, G. (2020). Expanding humanitarian forensic action: An approach to US cold cases. *Forensic Anthropology*, *3*(1), 50–58.

Goodyear, S. (2019, November 28). As U.S. launches its own MMIWG task force, some Indigenous advocates are wary. *CBC News*. https://www.cbc.ca/radio/asithappens/as-it-happens-thursday-edition-1.5376805/as-u-s-launches-its-own-mmiwg-task-force-some-indigenous-advocates-are-wary-1.5376812

Hylton, K. (2012). Talk the talk, walk the walk: defining Critical Race Theory in research. *Race Ethnicity and Education, 15*(1), 23–41. https://doi.org/10.1080/13613324.2012.638862.

Johnstone, M., & Lee, E. (2022). A colonial legacy of cultural and epistemic genocide: limited education access, family dislocation and premature death of Indigenous Youth in Northern Ontario, Canada. *Whiteness and Education*, *9*(1), 36–50. https://doi.org/10.1080/23793406.2022.2136581

King, S. (2021). *Our hearts are not at rest: A critical look at the adequacy of Indigenous death investigations*. [MA thesis, Simon Fraser University]. https://summit.sfu.ca/item/34910

Lheidli T'enneh First Nation, Carrier Sekani Family Services, Carrier Sekani Tribal Council, Prince George Nechako Aboriginal Employment Training Association, and Prince George Native Friendship Center. (2006). *A collective voice for those who have been silenced - Highway of Tears Symposium report.* https://www.highwayoftears.org/uploads/Highway%20of%20Tears%20Symposium%20Recommendations%20Report%20-%20January%202013.pdf.

Maloney, M. S. (2018). *Death scene investigation: Procedural guide*. (2nd ed.) CRC Press.

Mandes, J. (2022, October 3). Families from Treaty 4 Saskatchewan left with unanswered questions about murdered loved ones. *Global News*. https://globalnews.ca/news/9173002/treaty-4-saskatchewan-families-unanswered-questions-murdered-women/#:~:text=Chelsea%20Poorman%20and%20Noelle%20O,from%20the%20Kawacatoose%20First%20Nation.

McDiarmid, J. (2019). *Highway of Tears: A true story of racism, indifference, and the pursuit of justice for Missing and Murdered Indigenous Women and Girls*. Doubleday Canada.

McGruder, M. (2022). Missing and murdered: Finding a solution to address the epidemic of Missing and Murdered Indigenous Women in Canada and classifying it as a "Canadian genocide". *American Indian Law Review*, 46(1), 115–154. https://digitalcommons.law.ou.edu/cgi/viewcontent.cgi?article=1740&context=ailr

Michalko, R. (2016). *Obstruction of justice: The search for truth on Canada's Highway of Tears*. Red Deer Press.

Morin, B. (2020, June 11). As the RCMP deny systemic racism, here's the real history. *Toronto Star*. https://www.thestar.com/opinion/contributors/as-the-rcmp-deny-

systemic-racism-here-s-the-real-history/article_26c02dfd-084b-5f32-ac16-b37d7503edbe.html

Narine, S. (2012). *UN will support Aboriginal women by studying the violence that surrounds them. Ammsa.com*, *30*(6). https://windspeaker.com/in-depth/un-will-support-aboriginal-women-by-studying-the-violence-that-surrounds-them

National Inquiry into Missing and Murdered Indigenous Women and Girls. (2017). *Truth-gathering process – part 1 public hearings Dze L K'ant Friendship Centre Hall Smithers, British Columbia*. Vol. 4–8. International Reporting Inc. Ottawa, Ontario.

National Inquiry into Missing and Murdered Indigenous Women and Girls. (2019). *Reclaiming power and place: Final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*. https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Executive_Summary.pdf

National Institute of Justice US, and United States National Medicolegal Review Panel. (2011). *Death investigation: A guide for the scene investigator (technical update)*. US Department of Justice, Office of Justice Programs and National Institute of Justice. District of Columbia: U.S. Dept. of Justice, Office of Justice Programs, National Institute of Justice.

Native Women's Association of Canada. (2020). *Report Card on Government Follow-up to Reclaiming Power and Place: Final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*. Native Women's Association of Canada. https://www.nwac.ca/wp-content/uploads/2020/06/REPORT-CARD.pdf

Perry, M. (2013a, September 4). After six months, Brooks family still seeks justice in Prince Rupert. *The Northern View*. https://www.thenorthernview.com/news/after-six-months-brooks-family-still-seeks-justice-in-prince-rupert/

Perry, M. (2013b, May 8). RCMP actions questioned as candlelight ceremony honours youth found dead at Prince Rupert waterfront. *The Northern View*. https://www.thenorthernview.com/news/rcmp-actions-questioned-as-candlelight-ceremony-honours-youth-found-dead-at-prince-rupert-waterfront/

Razack, S. (2015). *Dying from improvement: Inquests and inquiries into Indigenous deaths in custody*. University of Toronto Press.

Razack, S. (2020). Settler colonialism, policing and racial terror: The police shooting of Loreal Tsingine. *Feminist Legal Studies, 28*(1), 1–20. https://doi.org/10.1007/s10691-020-09426-2

Rossmo, D. K. (2009). *Criminal investigative failures*. Taylor & Francis, Boca Raton, FL.

Royal Commission into Aboriginal Deaths in Custody. (1991). *Report of the Royal Commission*. https://www.naa.gov.au/explore-collection/first-australians/royal-commission-aboriginal-deaths-custody

Selket, K., Glover, M., & Palmer, S. (2015). Normalising post-mortems – whose cultural imperative? An Indigenous view on New Zealand post-mortem policy. *Kotuitui: New Zealand Journal of Social Sciences Online*, *10*(1), 1–9. https://doi.org/10.1080/1177083X.2014.901233

Smiles, D. (2018). "… to the grave": Autopsy, settler structures, and Indigenous counter-conduct. *Geoforum, 91*, 141–150.

St. Denis, J. (2023a, February 13). Chelsea, Noelle and Tatyanna went missing. Did police do enough to find them? *The Tyee*. https://thetyee.ca/News/2023/02/13/Chelsea-Noelle-Tatyanna-Went-Missing/

St. Denis, J. (2023b, February 28). Families charge 'police neglect' over missing person investigations." *The Tyee*. https://thetyee.ca/News/2023/02/28/Families-Charge-Police-Neglect-Over-Missing-Persons/

Talaga, T. (2017). *Seven fallen feathers: Racism, death, and hard truths in a northern city*. House of Anansi.

Tauri, J. M. (2014). Criminal justice as a colonial project in contemporary settler colonialism. *African Journal of Criminology and Justice Studies*, *8*(1), 20–37.

Thomas, S. (2014, April 9). Family of young Prince Rupert man refutes autopsy report. *The Northern View*. https://www.thenorthernview.com/news/family-of-young-prince-rupert-man-refutes-autopsy-report/

Truth and Reconciliation Commission of Canada. (2015). *Truth and Reconciliation Commission of Canada: Calls to action.* http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

Tsirtsakis, A. (2021, April 15). Deaths in custody: 'Every Aboriginal family has a story'. *RACGP.* https://www1.racgp.org.au/newsgp/clinical/deaths-in-custody-every-aboriginal-family-has-a-st

Tyson, C. (2003). Research, race, and an epistemology of emancipation. *Counterpoints, 195*, 19–28.

United Nations. (2007). *United Nations Declaration on the Rights of Indigenous Peoples*. https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

United Nations Office of the High Commissioner on Human Rights (2017). *The Minnesota Protocol on the investigation of potentially unlawful death.* https://www.ohchr.org/sites/default/files/Documents/Publications/MinnesotaProtocol.pdf

Watkins, K., Anderson, G. S., Bulmer, W., & Rondinelli, V. (2019). *Evidence and investigation: From the crime scene to the courtroom*. (2nd ed.) Emond Publishing.

Whittaker, A. (2021, April 5). Indigenous deaths in custody: Inquests can be sites of justice or administrative violence. *The Conversation*. https://theconversation.com/indigenous-deaths-in-custody-inquests-can-be-sites-of-justice-or-administrative-violence-158126

**Cases and legislation cited**

*R v Stinchcombe, [1991] 3 SCR 326.*
*BC Police Act, RSBC 1996, c 367.*
*Canadian Victims Bill of Rights, SC 2015, c 13, s 2.*
*Coroners Act, SBC 2007, c 15.*
*RCMP Act, RSC 1985, c R-10.*

**Endnotes**

[i] Hereafter, "UN High Commissioner."

[ii] A 'not applicable' score included investigative standards that would have been mandatory for one case but not for others. For example, investigative practice specific to cases involving minors were assessed for both Kayla McKay and Emmalee McLean's cases but were not applicable for Justin Brooks' case as he was over the age of 18. A 'not applicable' score did not factor into the total adequacy score.

[iii] A more detailed table showing how each case was scored appears in King (2021).

This page is intentionally left blank.