“Our hearts are not at rest”: A critical look at the adequacy of Indigenous death investigations

by

Steff King

B.Sc. (Anthropology), University of Idaho, 2018
B.Sc. (Sociology-Criminology emphasis), University of Idaho, 2018

Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Arts

in the

School of Criminology

Faculty of Arts and Social Sciences

SIMON FRASER UNIVERSITY

Summer 2021

Declaration of Committee

Name:	**Steff King**
Degree:	**Master of Arts**
Thesis title:	**"Our hearts are not at rest": A critical look at the adequacy of Indigenous death investigations**
Committee:	**Chair:** Sheri Fabian University Lecturer, Criminology
	Gail S. Anderson Supervisor Professor, Criminology
	Ted Palys Committee Member Professor, Criminology
	annie ross Committee Member Professor, Indigenous Studies
	Dara Culhane Examiner Professor, Sociology and Anthropology

Ethics Statement

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

a. human research ethics approval from the Simon Fraser University Office of Research Ethics

or

b. advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University

or has conducted the research

c. as a co-investigator, collaborator, or research assistant in a research project approved in advance.

A copy of the approval letter has been filed with the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Simon Fraser University Library
Burnaby, British Columbia, Canada

Update Spring 2016

Abstract

Across Canada, thousands of Indigenous testimonies have reported deficiencies in how police and medico-legal professionals investigate their deaths. The problem, however, is that these individuals are summarily and systematically denied the resources to challenge investigators and there are few cases that have done so successfully. This research establishes a comparative model to examine whether case investigation conduct aligns with standard investigative practice requirements. The qualitative sample includes three Indigenous case studies involving the suspicious deaths of young individuals in Prince Rupert, BC. The results present a central theme of inadequacy across all three cases, primarily in improper evidence collection, limited procedural follow-through, and withheld information. The outcomes of this study suggest a need for (1) future research and (2) professional action to create and uphold effective accountability measures for investigators and a critical look into how colonial powers limit investigative effectiveness for Indigenous deaths.

Keywords: Indigenous; Death investigation; Police misconduct; Standard practice; Medico-legal

Dedication

To Loved Ones, their Families, and Ancestral and Contemporary Communities.

Acknowledgements

Foremost, I would like to express my deepest gratitude to Kayla McKay, Emmalee McLean, and Justin Brooks' family for trusting me and the rest of the research team to conduct this study. No family should have to endure the pain you have suffered, and I admire you all for your strength and resilience over these years.

I also give my immense appreciation and thanks to my senior supervisor, Dr. Gail Anderson, for her guidance over these past two years. I have become more confident in my career pursuit as a coroner because of your invitations to new experiences, professional introductions, and chats about the past. I look forward to working with you in my PhD and to our future conversations about the animals in our lives.

I am grateful for the additional guidance and support provided by my secondary supervisor Dr. Ted Palys and my committee member Dr. annie ross. I am honored to have been invited into your research and thank you both for your help throughout. I look forward to future conversations with you both as I will always have much to learn about Indigenous studies and how to conduct research with care.

I would also like to acknowledge the invaluable help and dedication that came from Christine Martin, Jenna Forbes, and everyone who played a part in examining the events of these investigations since 2013. Your caring and supportive relationships with the families are inspiring to me as a young academic. I have found optimism for a more just future having connected with such dedicated people. I hope we may continue our conversations and work together to try and create meaningful change for other families.

I would like to give special thanks to Dr. Omi Hodwitz for her continued support and guidance over these past four years. I have become a more confident person and researcher because of your firm yet fair advice. Also, thank you for your insistence that Vancouver would make an ideal home for me. You were right. It is.

Additional thanks go to my peers in the SFU criminology department and the Centre for Forensic Research for the resource recommendations and suggestions on how to best

navigate a thesis as a busy student. Thank you also to my work-study students and research assistants for your countless hours hunting down information for me – you saved me weeks of searching for sparse information.

Thank you to my family and my personal community across Canada and the U.S. You all have played a part in getting me to where I am today and I value all of your insistence that I also live life while writing my thesis.

And of course, thank you to Zika the cat for your notes while I repeatedly read aloud my thesis over the past year and for your loud encouraging ‘wows’ while I defended my thesis from home.

Table of Contents

List of Tables

List of Acronyms

ACPO	Association of Chief Police Officers
BCCS	British Columbia Coroners Service
CRCC	Civilian Review and Complaints Commission
CRT	Critical Race Theory
FNHA	First Nations Health Authority
GPT	Group Position Theory
MCM	Major Case Management
MMIWG	Missing and Murdered Indigenous Women and Girls
MWCI	Missing Women Commission of Inquiry
MWWS	Missing White Woman Syndrome
NCPE	National Centre for Policing Excellence
NGO	Non-Governmental Organization
NIMMIWG	National Inquiry into Missing and Murdered Indigenous Women and Girls
NMRP	National Medico-legal Review Panel
NWAC	Native Women's Association of Canada
PI	Private Investigator
RCAP	Royal Commission on Aboriginal People
RCMP	Royal Canadian Mounted Police
REB	Research Ethics Board
SFU	Simon Fraser University
TRCC	Truth and Reconciliation Commission of Canada
UNHROHC	United Nations Human Rights Office of the High Commissioner
UBCIC	Union of the British Columbia Indian Chiefs
VATJSS	Vancouver Aboriginal Transformative Justice Service Society

Glossary

Investigator	This term is generalized to refer to both law enforcement and medico-legal death investigators throughout the research.
Medico-legal	Application of medical death and legal investigation. For this study, medico-legal professionals involve coroners, medical examiners, and forensic pathologists; all who investigate the cause and manner of death

Preface

In 2004, a young girl, 13-year-old Kayla McKay, died mysteriously on a spring night, but the subsequent investigation into her death left more questions than answers. In 2010, another young girl, 16-year-old Emmalee McLean, also died in the night at a party, but the investigators told the family nothing of what had happened. In 2013, the community lost another young life as 21-year-old Justin Brooks died suspiciously in the night at the waterfront, but the case opened and closed many times as investigators selectively ignored his family's request for information. These young people were all Indigenous and from the same local waterfront community in Prince Rupert, BC. Each of the three families, who suffered the tragic loss of their children, experienced additional harm having to navigate through death investigations with little support or understanding by the local RCMP and coroners. By 2013, instances of inadequate Indigenous death investigations became a common story throughout their community. Tired of the persistent systemic issues and lacking investigator accountability, a group of advocates began to support the families' fight for justice.

In BC, the Aboriginal Justice Strategy funds 33 programs that provide alternative justice resources for Indigenous people in both reserve and urban settings. Justin Brooks' family was assigned to one of the strategy's Prince Rupert programs in 2013. The concern, however, was that this program, and the family, would suffer negative repercussions by filing a complaint against the RCMP. Both a representative from the program and Justin's mother reached out to the then executive director of Vancouver Aboriginal Transformative Justice Services Society (VATJSS), Christine Martin, for help on how to begin the complaint process. Martin was a perfect choice for the job as she has roots in the community, knew the family well and, after speaking with Justin's mother, let the program know that she would advocate on behalf of the family thereafter.

This community inquiry grew larger as Christine Martin approached Grand Chief Stewart Phillip of the Union of BC Indian Chiefs (UBCIC) and Executive Director Josh Patterson of the BC Civil Liberties Association (BCCLA) seeking support in advocating

for the families. As the group began their investigation into Justin Brooks' death, they included Kayla McKay and Emmalee McLean's cases in the discussion because they shared stark similarities in investigative inadequacy. The goal of their project was to provide support for each of the three families and raise awareness about the three death investigations. VATJSS, UBCIC, and BCCLA also sought to challenge the systemic problems with policing in the local community and the province against Indigenous people.

In May 2013, Christine Martin and Micheal Vonn, the policy director of BCCLA at the time, met with the Prince Rupert RCMP - the day before Justin Brooks' candlelight vigil - to inquire about the three investigations. The investigators' response was diplomatic at best and provided little in terms of solutions for the future. Then began a long process of information gathering by the VATJSS, UBCIC, and BCCLA team as the RCMP and local coroners were not providing useful answers when asked. It was a close-knit collective effort by those involved – everyone lending a hand in what they did best. Vonn and Patterson provided a legal and policy review of the adequacy of each investigation, according to the RCMP and BC Coroners Service standards, but had difficulty defining adequacy without accessible regulations. Martin and Justin Brooks' mother filed a complaint against the Prince Rupert detachment leading an investigator from Prince George to come and review the case again. When little information came of that, they hired a private investigator to reinvestigate, paid for by the family's immense fundraising.

In 2014, the team invited two academic researchers from Simon Fraser University, Dr. Ted Palys and Dr. annie ross, to examine the ethical and systematic injustice concerns of each case. The goal was to have both Palys and ross - well equipped with their backgrounds in ethics, Indigenous advocacy, and institutional injustice - examine the nature of each investigation and write a piece on the denial of justice dealt to each family by the RCMP and coroners. This inquiry involved professionals and advocates, both Indigenous and not, coming together to review the events of the three cases and create solutions to bring the families peace. The data-gathering phase for the academic written work thus respected and reflected that process. In the same year, Palys

and Martin traveled to Prince Rupert to speak with each of the families – Kayla McKay's grandparents, Emmalee McLean's aunt, and Justin Brooks' mother – to learn about the events of each investigation and the roles of the RCMP and coroners.

I came into this project in 2020, midway through my criminology master's program at Simon Fraser University. I had spent the previous five years in Idaho, first getting my Bachelor of Science degrees in anthropology and criminology, and then working for a year in archaeology on United States Indigenous collections repatriation. My community from that time taught me the value of supporting others through instances of injustice, how to use research as a tool to challenge outdated practices, how to work in collective efforts towards common goals, and the importance of personal communication and storytelling. Before this, I benefitted from interning with a family mortuary in Washington state, where I learned how to help families navigate the death and mourning processes and create death management procedures that best supported the families' wishes. These values came with me to BC as I began my graduate studies interested in pursuing a thesis related to Indigenous death investigation and forensic practices.

My invitation to this important, and long-standing, project came from Dr. Ted Palys after having demonstrated my dedication to writing on Indigenous injustice and colonial practices (i.e., repatriation) in my coursework. I had spent the first year of my master's program researching the Highway of Tears cases and the forensic practices reported for each, under Dr. Gail Anderson, a well-known forensic entomologist and a regular consultant for investigations. Our focus on forensic practice and death investigation procedures provided a new focus for review for the three Prince Rupert cases. There was a cursory meeting to discuss the fit and general information of the project with my research capabilities and style that included me, Palys, Anderson, and an introduction and vetting to ross and the current executive director of VATJSS, Jenna Forbes. Our collective agreement was that my study should benefit and support the families. The purpose became determining the adequacy of each death investigation by comparing police and medico-legal standard regulations to case conduct.

Constructing this study was reliant on the many dialogues and relationships built before my inclusion in the project. My understandings and conceptualizations of each case came from the dedicated work, and trust established, by Forbes, Martin, Palys, Patterson, Phillip, ross, Vonn, the families, and the Prince Rupert community over many years. Additionally, my understandings of police and coroner standards came from the guidance of Anderson - and some of my SFU forensics peers - who has a lifetime of knowledge and professional connections to find that elusive information.

Case information access relied on the establishment and ongoing trust between the families, the community, and the research team. Martin and Palys' interviews with the families in 2014 relied on a relationship that prioritized personal wellbeing and care over the goals of research results. The case review effort by VATJSS, UBCIC, and BCCLA from 2013 onward operated on that same principle of trust and support. My relationship-building process began with those involved in the review and research of the three cases. First, with introduction and vetting by Palys, followed by conversations with Forbes, Martin, ross, and Vonn individually about the nature of the investigations and how best to support the families with my research. These conversations included official interviews in the winter of 2021 with Martin and Vonn about their recollections of the cases. The consensus of the research team was that I should introduce myself, and the purpose of my research, in a written letter to each of the families (passed on by Martin). It was then that I asked each family's permission for access to additional case files held by VATJSS and informed them of their right to review and edit the final research product and suggest where it could be presented.

My master's thesis is a culmination of all these events and efforts from 2013 to the present. The research uses police and medico-legal regulations to examine the adequacy of Kayla McKay, Emmalee McLean, and Justin Brooks' investigations to contribute to the research team's review of each case. It also contextualizes the larger issue of Indigenous injustice and systemic institutional problems that play a hand in the frequency of inadequate Indigenous death investigations in Canada. My goal is to support the families' desire for information by providing both a systematic review of police and coroner conduct in each case and a detailed summary of investigative standard practices

for their reference should they need it. As a white academic, I have immense privilege in my power of voice and access to professional channels. With permission from the families, I hope to use that privilege by presenting my findings to the academic and practitioner realms as investigative inadequacy is a persistent problem for the Indigenous community that requires wider attention and solutions.

Chapter 1. Introduction

1.1. Indigenous Deaths in Canada

> *It's like the same story all over again, but just a different child.* (Emmalee McLean's aunt)

Between May 2017 and October 2018, over 2,380 Indigenous families came forward before the Canadian public and government to give testimony regarding the disappearance and suspected or proven murder of their loved ones, and that the resulting investigations were either incomplete or non-existent (NIMMIWG, 2019, p. 49). This was the National Inquiry into Missing and Murdered Indigenous Women and Girls which was one of many inquiries to try to call "for transformative legal and social changes to resolve the crisis that has devastated Indigenous communities" (NIMMIWG, n.d., para. 1). Across the country, testimonies on Indigenous death investigations conducted by law enforcement and medico-legal professionals presented central themes including everything from denial of victimhood when missing persons reports were filed or refused, mishandling and improperly storing vital evidence, refusal to show the family the remains of loved ones, and waiting years to inform the next of kin the cause of death (Lheidli T'enneh First Nation et al., 2006; NIMMIWG, 2019; McDiarmid, 2019; Michalko, 2016). These are but a few of the many concerns brought forth by Indigenous people/s and are all a part of the enduring legacy of colonialism, intergenerational trauma, institutional racism, and perpetual victimization (Amnesty International, 2015; Lheidli T'enneh First Nation et al., 2006; NIMMWG, 2019; NWAC, 2010).

The severity of the situation intensifies when mortality statistics unveil just how common it is for Indigenous people to fall prey to an untimely death in Canada, creating more opportunities for investigations to fall short, if they are conducted at all. Academics Akee and Feir (2018) uncovered a notable overrepresentation of Indigenous deaths, compared to non-Indigenous Canadians, in their research regarding mortality data. Between 2010 and 2013, their results indicated that Indigenous groups had a consistently higher probability of early death than the general Canadian population, an outcome that has been true for decades and more. This was consistent among specific sex and age demographics as the mortality rate for Indigenous women and girls was three to four times higher than non-Indigenous females. On reserves, Indigenous men had a 31 percent probability of death before the age of 64 while the probability for their non-Indigenous counterparts were only 14 percent. The female rates are consistent with the concerns posed by the frequent inquiries into Missing and Murdered Indigenous Women and Girls (MMIWG) across the country, but statistics show that Indigenous men also represent a concerning disparity in mortality rates, demanding future discussion on their inclusion in the national conversation (Hansen & Dim, 2019).

Young Indigenous people also represent many of the missing and murdered cases in these discussions, a demographic that is also overrepresented in Canadian mortality statistics (Akee & Feir, 2018). Table 1 shows that within the younger age brackets, Indigenous females had approximately double the likelihood of dying at a young age than the females in the general Canadian population. Indigenous males were similarly more likely to die an early death than the broader Canadian population. Death at young ages is unnatural and unexpected, but as Indigenous people continue to die as youths or young

adults, this raises concerns about how a normalizing effect may hinder future investigations (Longstaffe, 2017; Michalko, 2016; Strega et al., 2014).

		Likelihood of death by		
		Age 15	Age 20	Age 25
Females	Indigenous	1.0%	1.4%	2.0%
	Cdn. Pop'n	0.6%	0.7%	0.9%
Males	Indigenous	0.8%	1.5%	2.3%
	Cdn. Pop'n	0.7%	0.9%	1.3%

Table 1.1 Likelihood of death by age for Indigenous people and overall Canadian population (Akee & Feir, 2018)

These mortality statistics provide a grim view of the degree of victimization towards young Indigenous men and women in Canada. Unfortunately, there is another trend uncovered in repeated research that garners further attention: a large proportion of these deaths are determined as accidental drownings, often with the noted presence of alcohol and intoxication (BCCS & FNHA, 2017; Giles et al., 2014). In a BC study of 95 Indigenous youth deaths between 2010 and 2015, the BC Coroners Service (BCCS) and the First Nations Health Authority (FNHA) determined that "accidental deaths (motor vehicle crashes, overdose, drowning and fire) accounted for 60% of all First Nations youth and young adult unexpected deaths" (2017, p. iv). Of these, poisoning by acute intoxication (i.e., drugs and/or alcohol) was the second most common cause of death and was at least a contributing factor in over half of the cases (BCCS & FNHA, 2017). Of the Indigenous youth and young adult drowning cases included in the review, 66% involved impairment by alcohol or drugs. Additionally, between 2012 and 2016, drowning rates were reported to be higher for Indigenous people compared with non-Indigenous people (Lifesaving Society Canada, 2019).

Suicide is the second most common manner of death reported in Indigenous mortality statistics, representing a third of youth deaths in the BCCS & FNHA 2017 study. Indigenous youth suicide is a well-known health disparity in Canada that has ties to societal, historical, cultural, and familial trauma, as well as the lack of health services available to support Indigenous people (Barker, Goodman, & DeBeck, 2017; Talaga, 2017). Death statistics suggest some truth to the trend of accidental or suicidal manner of death for the Indigenous population in Canada. However, these reports rely on data provided by investigator determinations. If death investigations are as inadequate as many Indigenous families claim, how can we be confident in the data that informs our understanding of Indigenous mortality?[1]

The distrustful relationship between investigators and Indigenous communities comes in part from the intergenerational trauma incited by legacies of colonialism, institutional racism, the RCMP's defense of resource extraction companies on Indigenous territories, the subsequent arrest of land protectors and Elders, and the cold fact that the RCMP once ripped Indigenous children away from their families in order to attend the Indian Residential Schools (Comack, 2012; NIMMIWG, 2019; NWAC, 2010; TRCC, 2015a). These institutional controls create and maintain the risk factors that influence Indigenous death and victimization trends, including deteriorating health concerns, alcoholism and substance abuse, unemployment, and the threat of violence and injury, amongst many others. While these are very real concerns towards a vulnerable population, some suggest that these known outcomes play a hand in how institutions may

[1] Academics would do well to investigate the credibility of mortality statistics that are based on investigator determinations. Statistic inaccuracies may negatively impact counter measures aimed at supporting Indigenous wellbeing when they are informed by the research and government reports that use them.

dismiss Indigenous people as true victims (McDiarmid, 2019; Strega et al., 2014). McDiarmid (2019) and Michalko (2016), both researchers in MMIWG investigations, explain that Indigenous stereotypes, such as perpetuating alcoholism, domestic violence, or runaway status, often become blinding rationales for determinations of deaths without proper investigation. Many of the families and advocates asserting that their death investigations have not been conducted adequately hypothesize that it may be due to these racial stigmatizations and assumptions. The regularity with which these concerns occur, without institutional effort to rectify them, only further tarnishes the relationship between investigators and Indigenous communities and distances the chances for developing solutions.

1.2. Purpose of the Study

The discussion above reveals that there is no shortage of Indigenous families who feel that their loved ones' deaths were not investigated appropriately. There are a variety of factors in Canada that contribute to the number of suspicious Indigenous deaths and a recently invigorated national discussion on how to address these circumstances, but how does one assess investigative inadequacy? While it is public knowledge that there is a trend in Indigenous claims of inadequate death investigations across Canada, there are little to no data, outside of judicial inquiry testimonies, to support these claims and no clear metric through which to evaluate it.[2]

[2] Public and government inquiries, such as the TRCC, MWCI, NIMMIWG, and others, include informative testimonial data collected from personal accounts of events and injustices. These data would best support further academic research to inform future practice and critiques of modern investigative misconduct.

As summarized in the preface, the current study began after an initial inquiry orchestrated by VATJSS, UBCIC, and BCCLA to address the concerns of the three families in Prince Rupert, British Columbia who believed their children's suspicious deaths were not investigated thoroughly by both law enforcement and coroners. The extensive data they had gathered were supplemented by further interviews and archival analysis to determine whether the investigators involved in these cases demonstrated adequate conduct as provided by investigative standard practice guidelines for law enforcement and medico-legal professionals.

The three investigations allowed for a multi-case explanatory qualitative study given the personal nature of the information and my goals of examining conduct adequacy. Each case details the families' recollection of events following the death of their loved ones. Their interviews unveil each investigation timeline and their emotions and reflections on those events. The research also relies on the experiences of the family advocates and research team about their work reviewing each investigation and challenging investigators. The qualitative design allows me to explore the case events in the narrative manner presented in the interviews and case files. Additionally, the research team and the families have questioned the adequacy of each investigation, which provides a clear focus for the research and thus an explanatory design. This refined the analysis of the data to focus on the adequacy of investigative conduct and any trends that suggested explanations to inadequate outcomes.

The research design comprised two phases: (1) a document analysis of death investigation procedure resources to create a standard practice summary in which to compare case study conduct; and (2) a comparative design between the three Indigenous

death investigations and the standard practice summary which assessed either adequate, inadequate, or not applicable conduct for procedural steps. Data included Martin and Palys's interviews with the decedents' families in 2014, about the nature of each investigation and their relationship with investigators, as well as the case files collected by VATJSS, UBCIC, and BCCLA on behalf of the families from 2013 onward, and my additional interviews with Martin and Vonn in 2021.

1.3. Research Question

The problem with arguing whether an investigation was conducted adequately enough is that there is no set reference for what 'adequate' means or what metric best determines the answer. There does not appear to be any academic research on the integrity of death investigative conduct, so this research shares the methodological framework of legal assessments.[3] This is best exemplified in the recent review of the death of young Indigenous man Colten Boushie, who was shot and killed in 2016 (CRCC, 2021). The RCMP launched a criminal investigation into Boushie's death which resulted in an acquitted murder charge after concerns were raised about the RCMP's actions in the case. The Civilian Review and Complaints Commission (CRCC) for the RCMP, tasked with assessing the conduct of the investigation, used a comparative design that provided a useful template that was adapted for this research – comparing the investigative conduct to police and medico-legal standard practice guidelines – to determine if professionals adequately investigated the case.

[3] There is a significant lack of academic focus on investigative inadequacies for marginalized communities despite the extensive literature available on related topics (i.e., racialized policing, Indigenous victimization, systemic racism and incarceration).

This legal design informed much of the present research in how to effectively assess investigations of this nature, while also using a narrative to which the RCMP and coroners would connect. The primary research question asked: How adequately were the three Indigenous death investigations in Prince Rupert conducted when compared with standard investigative procedures? It was hoped that a comparative design would be most likely to generate a definitive dichotomous 'adequate/inadequate' answer while allowing for an additional qualitative explanation for the overall outcome (i.e., to what degree were the investigations (in)adequate?).[4]

1.4. Thesis Outline

Chapter two summarizes existing literature that discusses victimization toward Indigenous people and the relationship between investigators, the public, and Indigenous communities in Canada. The chapter focuses both on aspects of the past that lead in part to the current issue of disproportionate Indigenous deaths and inadequate investigations, as well as the academic explanations for the situation and institutional responses to rectifying it thus far. It also provides an extensive look into other Indigenous investigations that present themes of inadequacy. The chapter concludes with an introduction to the three case studies and the events leading up to each death.

Chapter three explains the chosen research methods conducted to assess the adequacy of each case investigation. The overall study design is compartmentalized into

[4] Adequacy is a subjective term with varying definitions by differently involved communities. The present research defines adequacy as police and medico-legal conduct performed according to standard guidelines. Although this definition best allows for a critical examination of investigator conduct by their own standards, it does not properly align with how Indigenous families, or any other minority group, may determine adequacy. The results and discussion sections thus will create space for family reflections on where investigator-defined adequacy was not adequate by their own standards.

two parts: (1) the development of a standard investigative practice summary and (2) a comparison of each case study investigation to standard investigative practices. The reader also will be introduced to the selected sample and the data used in both phases of the analysis. The chapter concludes with a discussion of the ethical considerations of the study practices and the researcher's reflexive journey throughout.

Chapter four outlines the standard investigative practice summary to which the case studies are compared in chapter five. The summary serves as a baseline metric for which to compare investigative procedures in each case in order of operation. The summary details the procedures required by federal, provincial, academic, and professional resources for investigative best practice. Investigative best practice pertains to the processes and procedures determined by professionals in the field to solve cases. These procedures are considered best practice by scientific and judicial terms but may not align with what others would define as “best practice.” Chapter six will discuss this discrepancy in detail by connecting investigative best practice themes with needs for decolonization for a more inclusive definition.

Finally, chapter six discusses the overarching themes found in the research and provides additional recommendations regarding standard investigative practice guideline accessibility and decolonization. The chapter concludes with a summary of central themes present throughout the study, limitations to the research design and results, and provides suggestions for future research into Indigenous death investigations in greater detail in Canada and the United States.

Chapter 2. Literature Review

Significant facts and questions reside in the story of inadequate death investigations for Indigenous individuals, considering the lasting effects of Canada's colonial history and the strained relationship between government institutions and Indigenous communities. A wealth of literature and research attention has connected intergenerational trauma from colonial takeover at settlement and the lasting overrepresentation of Indigenous victimization and mortality rates across the country (Denis, 2020; Hargreaves, 2017; Monchalin, 2016; Nielsen, 2019; NIMMIWG, 2019; NWAC, 2019, TRCC, 2015a). There have also been a notable number of investigator misconduct reports for Indigenous death investigations, demonstrating repeat trends of inadequacy (Epstein, 2021; Lheidli T'enneh First Nation et. al., 2006; NIMMIWG, 2019). Indigenous rights advocates and non-governmental organizations (NGOs) have garnered further national attention to these concerns by calling for federal ownership and solutions, while also pointing collective fingers at agencies that have histories of contributing to the problem without notable consequence.

This chapter will provide contextual background on Canada's relationship with the overall Indigenous community as it pertains to victimization and death investigation.[5] I begin with a review of the existing literature that provides theoretical and conceptual explanations for ongoing Indigenous mistreatment and institutional inattention. Multiple Indigenous case examples and central themes of investigative inadequacy will help

[5] I would like to acknowledge the unique differences that make up the various Indigenous communities in Canada. While the research will generalize to the 'Indigenous community' throughout, this is not to undermine the complex and valued characteristics that make up each individual Nation, band, territory, and/or familial group. When citing existing literature, the specific terminology referenced will be used.

illustrate the prevalence of this issue. These are followed with a review of national and provincial efforts to rectify this situation. Finally, the chapter concludes with an introduction to the case studies analyzed in this research. By the end of this section, the reader should understand the significance of existing claims of investigative inadequacy of Indigenous deaths given this ongoing concern since the colonial era.

2.1. How Did We Get Here?

There is a long list of events, decisions, and consequences that have led to so many Indigenous testimonies of investigative inadequacies (some of which are discussed in this section). Researchers have posited various possible influences on why this is, but the common link between them is colonialism (Denis, 2020; Hargreaves, 2017; Monchalin, 2016; Nielsen, 2019).

2.1.1. Injustice Through Time

Many attribute settler-colonial mistreatment of Indigenous people/s as a purely historical event, giving the impression that the government's harmful actions are a thing of the distant past. The literature tells a different story – that these injustices happened not only long ago but also persist into modern practice with measurable harm.

The arrival of colonizers in the 17th century symbolized a beginning to the long road of injustice towards Indigenous people/s. Colonizers came intending to reap the benefits of new land and resources to build a market abroad and offload some of their population into "uncultivated" lands; this did not align with the fact that the land was already occupied by native life (Comack, 2012; Razack, 2018). The actions of colonial

governments and their settlers are both egregious and complex, including seizing land through treaty and non-treaty agreements, abandoning trade reciprocity for control of resources, starving Indigenous people from their homes, creating political and militarized alliances between Indigenous and non-Indigenous people against violent settlers, and many others (Hamilton & Sinclair, 1991; McLeod, 2000; Razack, 2018). Settlers first expected and then attempted to force Indigenous people to abandon their ways of life, using everything from dispossession to starvation to removal (Royal Commission of Aboriginal Peoples, 1996). What came next was defining Indigenous identity and forced assimilation to European values.

The 1876 *Indian Act* granted the Canadian federal government legislative authority over those who fit within their narrow requirements for "Indian" status, creating laws that restricted where Indigenous people could live, how their lives would be governed, and who qualified as a "status Indian" (Inter-American Commission on Human Rights, 2014). Familial structure was redefined as women were removed from their traditional matriarchal leadership roles while patriarchal rules informed daily life and determined a social hierarchy, stripping away Indigenous women's decision-making abilities and equality within their own communities (Gibbins & Ponting, 1986; Hargreaves, 2017). Additionally, an Indigenous woman who married a non-Indigenous man lost her legal status – as well as her children – but a non-Indigenous woman who married an Indigenous man gained legal status for herself and her children.

The Indian Act further restricted everyday life. Indian agents become an authority that determined whether Indigenous people/s were following the many regulations set

against them (Comack, 2012). For instance, vagrancy and trespass laws under the Criminal Code and Indian Act restricted mobility; Indigenous people were confined to their reserves unless they secured a pass from an Indian agent to leave (Hamilton & Sinclair, 1991). In 1884, the Indian Act imposed status offenses for the practice and demonstration of cultural ceremonies which could result in imprisonment (Comack, 2012). This was a direct affront to Indigenous culture as Anglican missionaries associated Indigenous beliefs and practices with savagery and uncivility (McCalla & Satzewich, 2002).

Beginning in the 1880s, the Canadian, and United States, government appointed religious organizations and churches to assimilate and "civilize" Indigenous children using the residential school system (Comack, 2012; Hargreaves, 2017). Residential schools became mandatory by law in 1916, allowing Indian agents and the RCMP to forcibly take children from their homes to attend (Hamilton & Sinclair, 1991; RCAP, 1996; Truth and Reconciliation Commission of Canada, 2015a, pp. 2-6). The treatment of these children while in residential schools was inhumane: many children were not provided adequate food, clothing, or health care; many were physically and sexually abused by staff; many children attempted suicide; and thousands never returned home to their families. The trauma from residential schools is far from a distant historical memory - with the last school closed in 1996 - many Indigenous survivors still speak about the lasting effects the physical, psychological, and sexual abuse had on them throughout their lives (NIMMIWG, 2019, pp. 111-113, 259-266). Many of the families exposed to residential schooling, either by attending or having their children taken away, are still

affected by institutionalized violence, leading to a community of over-representation in poverty, addiction, and exposure to harm (Hargreaves, 2017).

Although the Canadian government claims to be attempting to reconcile with Indigenous peoples for the lasting harm that these colonial powers have enacted on the Indigenous population, the effects are deep-rooted (TRCC, 2015b, pp. 1-20). Many Indigenous families lost connections to their culture, be it through a loss of status or educational reprogramming, and continued effects of trauma have led to chemical dependencies and financial hardships. All the while, institutionalized racism survives in the modern realm whether federal parties publicly acknowledge it or not (NIMMWG, 2019, pp. 111-113, 259-266).

2.1.2. Colonialism as the Persistent Perpetrator

Settler colonial theory (SCT) often sits at the center of academic explanations for inadequate treatment of Indigenous people today by acknowledging the effects of intergenerational trauma that came from stripped land rights, restricted “Indian” status, residential schooling, and lifetimes of harm (Denis, 2020; Furniss, 1999; Macoun & Strakosch, 2013). The theory connects the current conflict between settler and Indigenous communities to the lasting colonial framework that persists into modern structural violence and institutional racism. Common rhetoric that survives in modern settler institutions includes rationalizing colonial behaviors as ‘for the greater good’ of society and perpetuating Indigenous people as weak or a force to be feared and controlled by white authority. Macoun and Strakosch (2013) further suggest that non-Indigenous academics, despite best intentions, often fall prey to settler-colonial thinking by treating

the Indigenous community as something to be saved without acknowledging that effective change cannot come from ideals that enforced the problem to begin with. Colonial thinking maintains a racist ideal of control over marginalized populations, allowing, for example, early Indian Agents to forcibly remove children from their homes, for Indigenous deaths to repeatedly go under-investigated, and for the unchallenged dismissal of Indigenous people dying while under government care (Hargreaves, 2017; NIMMWG, 2017; TRCC, 2015a). Distrust is warranted as the scars of the past did not fade and children have learned from their parents about the horrors of what institutions did to their people. There is a wealth of literature that cites this lasting trauma as the driving force to modern Indigenous victimization and the inadequacy of the investigations to address it (Amnesty International, 2009, Boyce, 2015; NIMMWG, 2019; NWAC, 2010, 2019; Perrault, 2015; RCMP, 2015).

2.1.3. Distrust in Police

Lacking sympathy, under-enthused diligence, and a racial bias aimed at enforcing the expectant Indigenous victim only further impairs the relationship between law enforcement and the Indigenous community (Ben-Porat, 2008). Added to this are the repeat occurrences of law enforcement targeting Indigenous people/s for surveillance, ignoring their needs and requests for help, denying equal rights to justice, arresting Elders and others for defending the land, and countless other injustices. Indigenous people have a long colonial history of reasons to feel distrustful of law enforcement and other investigative government roles, and recent concern regarding police violence and malpractice against marginalized communities only reinforces this distance (Chrismas, 2012; Comack, 2012). Cao (2014) found that Indigenous people have a “significantly

lower level of confidence in police" compared with other Canadians (p. 515). Acts of violence perpetrated by police create a sense of unease in the targeted communities; this includes news reports of "starlight tours" in Saskatoon and research studies finding high rates of Indigenous mortality while in police custody (Cao, 2014; Comack, 2012; Razack, 2015; Reifenberg, 2018). It does not require an academic to explain that those who incite harm against you may not be the first people you call to help investigate why your family was also victimized.

2.1.4. Critical Race Theory and Unequal Investigations

The relationship between Canadian institutions and the Indigenous population demonstrates a core argument of Critical Race Theory (CRT). CRT theorists posit "that society is fundamentally racially stratified and unequal, where power processes systematically disenfranchise racially oppressed people" (Hylton, 2012, p. 24). This creates a "lived oppression" as those who are racially oppressed cannot obtain power when the controlling system writes, and forever changes, the rules against them (Tyson, 2003, p. 20). Colonial ideologies are embedded in Canadian society and thus restrict Indigenous lifestyles and their ability to challenge government practices. The CRT framework uncovers central themes of unequal race relations and power dynamics in the claims of inadequate Indigenous death investigations and investigator misconduct.

In any investigation, the investigator holds the power for the outcome of the case, but when the victim is of a racially marginalized community, the investigator has a greater power to constrict and manipulate the case to fit their best interests without much resistance from the rest of colonial-white society (Delgado & Stefancic, 2021; Michalko,

2016; VanEvery, 2019). Indigenous communities have distrusted police for the misuse of the power they have over them and in how the institutions that are meant to review investigator misconduct come from the same colonial power position. There are numerous Indigenous death investigations that have clear indications of inadequate conduct, but by using the CRT lens, it is clear why they persist without solutions. The Canadian system upholds powers that prevent Indigenous people from challenging the system effectively, and their consistent victim status normalizes the targeting, oppression, and violence towards them.

CRT is an offshoot of critical legal studies, which examined the inequalities within the legal system based on a person's demographic characteristics. Theorists posited, in the many critical theory offshoots, that marginalized groups – whether by race, gender, sexuality, or others - could not benefit from the full functions of the legal system if there were no resources available or applicable to their identity (Crenshaw, 2018; Dunbar, 2008; VanEvery, 2019). The same thought process applies to the investigative realm as a critical race theorist may argue that Indigenous individuals would not be able to benefit from a full and adequate investigation if the standards and professionals provided do not support them. As the present research progresses, and Indigenous case examples uncover repeat themes of investigative inadequacy, the underlying tenets of CRT help shed light on just how much colonial powers impact Indigenous cases.

2.2. Inadequate Indigenous Investigations are Common

The present research is not the only attempt to address claims of inadequate Indigenous death investigations. Distrust in police has roots in colonial history but persists in the

modern sphere with numerous accounts of misconduct against Indigenous people/s. Families have presented their testimonies to the public, and before the Canadian government, to convey the commonalities in inadequate investigative procedure for their community. A seldom few of these cases have reached institutional review of this misconduct but, in doing so, present a clear path for how best to assess investigative inadequacy by comparing observed practice to the government's own standards.

2.2.1. Indigenous Testimonies

Many Indigenous families have conveyed their concerns about the death investigations of their loved ones to the public sphere through national and provincial inquiries (Lheidli T'enneh First Nation et. al, 2006; NIMMIWG, 2019). This attention further inspired authors and researchers to gather additional Indigenous stories and many families took to social media to ensure that their voices also were heard. Their combined messages told Canada that there are numerous suspicious Indigenous death cases and the majority of them do not receive standard investigative procedures. With particular focus on MMIWG cases, as recent inquiries have drawn missing and murdered Indigenous females more towards the light than others, public testimonies reveal six primary themes of investigative inadequacy shared across thousands of cases in Canada (Lheidli T'enneh First Nation et al, 2006; McDiarmid, 2019; Michalko, 2016; NIMMWG, 2019).

The first theme involves the media's often inaccurate portrayal of Indigenous victims while reporting investigation information to the public (Gilchrist, 2010; Longstaffe, 2017; NIMMIWG, 2017; Strega et al., 2014). Families frequently noted that when news reporters or investigators spoke of Indigenous victims in the news, they often

focused on characteristics that enforced stereotypes and incited victim blaming. This concern is well-investigated in academic literature given how often it occurs for Indigenous cases. Denis (2020) applies Group Position Theory (GPT) to discuss how institutional racism allows those in positions of power not only to ignore the plights of Indigenous communities in need but also to cast them as a threat and blame them for their victimhood. Studies on public messages about Indigenous deaths in the media explains that victim-blaming rhetoric often accompanies stories about Indigenous women who disappear or who are murdered, using dehumanizing terms like "prostitute" or "alcoholic," while non-Indigenous women in the same situation are cast using sympathizing terms (Gilchrist, 2010, Khajeh, 2020; Morton, 2016; Slakoff & Fradella, 2019). This process allows those in a position of power to rationalize why they put so little effort into investigating Indigenous cases as law enforcement officers are noted to believe that victims are victims by their own doing.

The second theme describes how Indigenous investigations often were overshadowed by non-Indigenous cases when covered in the media or addressed by police (Lheidli T'enneh First Nation et. al, 2006; McDiarmid, 2019; Michalko, 2016; NIMMWG, 2017). Families noticed stark differences in how non-Indigenous cases received more and better media coverage than Indigenous cases, and how non-Indigenous investigations had regular police updates and public recognition in the news compared to their own loved ones' investigations. This theme indicates a regular application of Missing White Woman Syndrome (MWWS), where researchers have identified a trend in how white female cases are typically portrayed in a more humanized light compared with non-white cases and thus garner more action and attention (Gilchrist, 2010; Moeke-

Pikering, Cote-Meek, & Pegoraro, 2018; Stillman, 2007). This syndrome was exemplified best in 2002 when the public were dismayed over the disappearance of a white girl and national attention towards finding her spanned several months. At the same time, quite a few missing Indigenous girls of the same age, educational background, and location, received little to no recognition (McDiarmid, 2019; Michalko, 2016). This public portrayal, or lack thereof, others Indigenous people, particularly when they are at their most vulnerable, and creates a normalizing effect when more deaths and missing persons claims are filed. From this, we see a resulting lack of determination and focus by the public and investigators whose duty it is to fully assess each case, Indigenous or otherwise.

The third and fourth theme go hand-in-hand as Indigenous testimonies repeatedly observed how investigators were slow to respond to missing persons reports and did not take cases seriously (McDiarmid, 2019; NIMMIWG, 2017). Many families explained that investigators dismissed them when they called to report their loved one as missing, either stating that they should wait 24 hours because they are likely just a runaway, or refusing to take the report at all. Former Vancouver Police Department detective and geographic profiler Kim Rossmo verified this common concern by explaining how investigators base responsivity on the concept of the "true innocent" (McDiarmid, 2019, p. 122). Akin to the Indigenous stereotyping and stigmatizing rhetoric used in the media, investigator preconceptions of what Indigenous people are likely doing (sex work, substance abuse, sudden relocation) overtakes their ability to see them as potential victims and respond accordingly. Rhonda Morgan, founder of the Missing Children Society of Canada, reflected that this slow responsivity and lack of serious effort

seriously hinders an investigation: “When you don’t take it seriously at the beginning, you lose out on too much valuable information” (McDiarmid, 2019, p.40).

The final two common themes in Indigenous testimonies relay that investigator silence does more harm than good. Many families felt that investigators kept them in the dark about important information during, and well after, their cases. This had them expressing feelings of abandonment and unsupported by investigative roles and institutions. Many started out trusting investigators to keep them updated throughout the case, relying on their information to feel reassured that progress was being made, but when these requests for updates went unacknowledged that trust began to wane (NIMMWG, 2017). Information commonly withheld included everything from the cause of death to the official closure of the case, leaving many families feeling as though they needed to investigate on their own when it did not appear that anyone else would.

These Indigenous testimonies identify considerable concerns in how police conduct their investigations. Families often witnessed that when investigators fell short on their duties, the community picked up the slack by launching their own investigations, because they refused to sit by while important evidence went uncovered. VPD homicide detective Steve Pranzl, member of the Highway of Tear's task force, noted, after so many run-ins with these inadequate efforts, that it takes an insurmountable amount of effort from the families to get investigators to take people seriously and respond accordingly (McDiarmid, 2019). Unfortunately, the majority of these Indigenous families have only their testimonies to argue against investigator conduct, meaning many inadequate investigations go unchecked by official bodies as they require physical evidence for proof. As public attention increases, however, some cases have risen through the cracks,

receiving federal attention, and confirmation, of investigator misconduct along these themes and other.

2.2.2. Reviewed Cases and Proof of Misconduct

There are, however, documented instances in which Indigenous investigations received the official review needed to assess investigator misconduct. Not many cases get to this point, but those that do, share many similarities. Of note, the cases of Colton Boushie, Alloura Wells, and Jordan Wabasse each reveal investigator misconduct by institutional standards.

Colten Boushie's (22 years old) death occurred in 2016 near Biggar, Saskatchewan, where he was shot and killed by a farmer, which launched a criminal investigation conducted by the RCMP (CRCC, 2021). The shooter was charged with murder but was eventually acquitted which stirred up concerns about the adequacy of the RCMP's investigative conduct. The Civilian Review and Complaints Commission (CRCC), a review body of the RCMP, launched a Public Interest Investigation into the criminal investigation finding multiple counts of inadequacy. In general, the CRCC determined that investigators did well in some regard by responding to the initial report in a timely manner, employing necessary resources where reasonable, and in how they interviewed the suspect. The inadequate conduct, however, demonstrated the wealth of testimonial themes of police power and insensitivity toward Indigenous victims. The commission reported that not only did investigators fail to collect important blood spatter evidence, they also demonstrated discriminatory behavior by questioning the mother's sobriety, searching parts of her home to verify her stories, and insensitively attending the

family wake without invitation. The CRCC went on to provide 17 recommendations including mandatory cultural sensitivity training for officers.

Alloura Wells' (27 years old) case underwent independent review by Justice Gloria Epstein in the report of *The Independent Civilian Review into Missing Persons Investigations* (2021). The review identified many cases involving vulnerable and marginalized victims that received a less than adequate response from investigators. Alloura Wells was remembered by members of her community as approachable, a great singer, and ambitious to achieve her goals for the future (Brown, 2018). She was also an Indigenous trans woman and sex-worker advocate who had struggled with drug abuse and homelessness (Epstein, 2021). Her family tried very hard to find her when she went missing, but the case received a myriad of inadequate responses by Toronto investigators. Justice Epstein concluded that the investigation involved both adequate and inadequate conduct. One detective did well by trying to identify her remains, once found, by using comparative databases and issuing internal bulletins. The remainder of the investigation, however, had clear deficiencies. Inadequate procedural conduct consisted of the denial of victimhood when no Missing Person Report was filed after her father contacted police, no clear identification of a lead investigator or notification of a homicide unit when the body was discovered, miscommunication between the coroner, police, and the family, and poor police attitudes and disrespect towards Wells' victim status.

Jordan Wabasse's case has received wide-scale public attention through Tanya Talaga's book *Seven Fallen Feathers* (2017). As an investigative journalist, Talaga examined Indigenous death investigations in Thunder Bay, Ontario; Jordan was only one of many that involved inadequate conduct. The story began when the 15-year-old did not

show up at his boarding house for supper one night. He was last seen by friends drinking as he got off the bus at his stop less than a block from his home; his body was eventually found by boaters floating in the Kam River three months later. What is interesting about the investigation of Jordan Wabasse's death, starting originally as a long missing persons case, was that there were many instances of adequate police conduct. Police started their search for the teen promptly after his Indigenous boarding parents reported him missing. They conducted a canvass of the area and aquatic search of the river, interviewed friends and community members, and submitted found clothing for forensics analysis. Once the body was recovered, investigators adequately delivered the death notification to the family in-person and proceeded to re-interview possible suspects. Where inadequacy occurred in the investigation is in how investigators settled on a quick determination of manner of death once the body was found. Wabasse's case was marked as "accidental … cold water drowning," based on investigator theory that, instead of walking the few paces home from the bus stop, he must have stumbled over 3 kilometers to the bridge and fallen over the high railing, into the river by accident (Talaga, 2017, pp.46-47). This determination also was inconsistent with the court testimony by another teen that claimed another boy had confessed to pushing him off the bridge. Reviewers of the case suggest that the determination may have been a convenient choice based on Indigenous stereotypes and mortality expectations.

Each of these three cases used investigative standard practices to uncover professional misconduct. The outcomes were consistent with Indigenous families' testimonies and demonstrated that the comparative method can be used effectively to assess investigative adequacy. These case reviews also revealed the fact that investigative

inadequacy occurs often for Indigenous cases and without repercussion to investigators, but this is not a new discovery of which Canadian institutions were unaware.

2.3. What Has Been Done?

The literature demonstrates how persistent and unchecked the Indigenous victimization and inadequate investigation situation is in Canada. The recent review of cases above, that demonstrate present themes of colonial power struggles, victim blaming, lack of investigator diligence, and family intimidation, boggles the mind considering the wealth of recommendations to government, police, and non-government organizations (NGO) to rectify this situation over the past few decades.

2.3.1. Government Action

Prime Minister Justin Trudeau's *Truth and Reconciliation Commission of Canada* came seven years after his predecessor, Stephen Harper, made a public apology on behalf of Canada for residential schooling (Dorrell, 2009; TRCC, 2015a).[6] While not specifically focused on investigating Indigenous deaths in the country, both apologies acknowledged the trauma caused by residential schooling to Indigenous people. The TRCC was an effort made for repairing the relationship between the Canadian government and Indigenous people/s. However, Canada is widely critiqued in that a simple apology is not

[6] Following the pressure of the public apology made by the Australian Prime Minister in 2008, and the negative press for Canada's refusal to adopt the United Nations *Declaration on the Rights of Indigenous Peoples* in 2007, Prime Minister Stephen Harper announced his own apology for residential schooling (Dorrell, 2009). The apology is critiqued for missing important facts of history, like banning cultural practices, and lacking recommendation follow through (Anderson, 2012). This apology is considered the initiation of Trudeau's TRCC. Harper also had little concern for acting on the missing and murdered Indigenous women and girls concern. He was famously quoted in an interview with Peter Mansbridge claiming, "It isn't really high on our radar, to be honest" (Maloney, 2015, para. 8). He went on to decidedly leave the issue up to the RCMP to handle.

sufficient for righting past wrongs, especially as Indigenous people continue to face marginalization and mistreatment (Smith, 2013). Subsequent reviews of the impacts of the TRCC have determined that many of its calls to action have gone unfulfilled and that the effort itself was more of a reconciliation aesthetic (Robinson & Martin, 2016). The insistence for a national inquiry into missing and murdered Indigenous women and girls was becoming more vocal across the country up to that point, however, which made certain that call to action 41 was set in motion:

> We call upon the federal government, in consultation with Aboriginal organizations, to appoint a public inquiry into the causes of, and remedies for, the disproportionate victimization of Aboriginal women and girls. The inquiry's mandate would include: i. Investigation into missing and murdered Aboriginal women and girls. ii. Links to the intergenerational legacy of residential schools. (TRCC, 2015b, p. 4)

Time passed with little to show on behalf of the government; Indigenous people still faced extreme poverty, still were at risk of violence because of their identity, and continued to go missing and be murdered without explanation (Arriagada, 2016; RCMP, 2015; Smith, 2015).

In 2011, the *Missing Women Commission of Inquiry* (MWCI), headed by Commissioner Wally Oppal, started a provincial investigation into the large proportion of women targeted in the Vancouver Downtown Eastside following the recent capture of notorious serial killer Robert Pickton and the negligent conduct in homicide investigations (Beniuk, 2012). This inquiry was not specific to Indigenous women but the message that Indigenous women represented a significant and "over-represented" portion of the victims in the area became clear. Schmalleger and Volk (2013) conducted an analysis on the missing and murdered women in Vancouver, and ultimately supported the

link between victimized Indigenous women and inadequate police investigations for each case, further supporting the need for the inquiry. Scholars argued that the MWCI used settler language and ideals, so while Indigenous women were not excluded entirely from the analysis, insufficient consideration was given to their culture and increased risk of victimization (Beniuk, 2012; Hargreaves, 2017). In the final MWCI report, *Forsaken,* Oppal provided a short section of recommendations dedicated to the prevention of Indigenous victimization. Amongst them is recommendation 6.2 which states:

> That Provincial Government fully supports the implementation of The Highway of Tears Symposium action plan, updated to the current situation and in a manner that ensures involvement of all affected communities along Highway 16. (Oppal, 2015, p. 165).

2.3.2. NGO and Indigenous Advocate Action

Trans-Canada Highway 16 is the centralized location of what many know as the 'Highway of Tears;' A 724-kilometer stretch of road connecting Prince Rupert to Prince George in British Columbia, and home to countless grieving families and cautious Indigenous people as it is notorious for its high rates of disappearances and unsolved deaths (Lheidli T'enneh First Nation et al., 2006; Michalko, 2016). The majority of the confirmed missing and murdered women and girls along the highway have been Indigenous, many of whom were last seen hitchhiking, a mode of transportation for many low-income people who need to travel out of town without access to a vehicle or bus service. The disproportionate representation of Indigenous women and girls to disappear along the Highway of Tears has brought on a variety of discussions about the issue (Lheidli T'enneh First Nation et al., 2006). In 2005, the *Take Back the Highway* campaign began from grassroots efforts of victims' families to raise public awareness. A

year later, the *Highway of Tears Awareness Walk* started in Prince Rupert, leading victims' families, friends, and community members to walk the entire length of the highway to end at the commencement of the long-awaited Highway of Tears Symposium. For two days, Indigenous families and delegates from across the country learned about existing MMIWG along the highway and created 33 recommendations for a community call to action. A common narrative amongst their stories was the inadequate investigation by police and medico-legal professionals (Lheidli T'enneh First Nation et al., 2006; McDiarmid, 2019) . While the symposium was not the first effort in Canadian history to address the disproportionate violence Indigenous women and girls experience, it was the first aimed at MMIWG specifically.

In 2016, the Canadian federal government, spearheaded by Indigenous advocacy groups and human rights NGOs, formally began the *National Inquiry into Missing and Murdered Indigenous Women and Girls* (NIMMIWG, 2019).[7] The inquiry allowed for Indigenous families and friends of MMIWG to speak to committee members about the nature of their loved one's disappearance and/or death, as well as talk about the realities of the investigations for those individuals, the history of racial injustice they and their family have experienced, and provide recommendations for how best to help Indigenous people. After listening to the emotional testimonies of hardship and intergenerational struggles of more than 2380 people across Canada, the NIMMIWG commission made 231 Calls for Justice, providing recommendations that would support Indigenous families across Canada and prevent further Indigenous women and girls from disappearing and

[7] This inquiry was long overdue. Canada was chastised in 2015 by the United Nations Human Rights Council Special Rapporteur, James Anaya, for the lack of accountability measures to address Indigenous victimization up till that point.

becoming victims of violence. The release of the inquiry's final report was in June of 2019, making it the most recent national conversation on the topic of MMIWG in the country. After a year, the Canadian government had already received a 'failing grade' from the Native Women's Association of Canada (NWAC) for the lack of follow-through with recommendations (Stefanovich, 2020). This failing grade was not solely for the NIMMIWG, as the recommendations made in the inquiries and public reports before it had gone largely unfulfilled as well. As it stands, the concern remains: will the testimonies of Indigenous investigation inadequacies continue to go unaddressed?

2.3.3. Police Action

Despite the strained relationship between law enforcement and the Indigenous community, the RCMP has developed its own action plans over the past few decades to investigate the MMIWG cases under their jurisdiction.

In 2001, *Project Evenhanded*, a joint probe between the RCMP and the Vancouver Police Department, began by investigating missing and murdered women in Vancouver's Downtown Eastside (Keller, 2012). While this project assisted with the conviction of notorious serial killer Robert Pickton, who was responsible for the murders of countless women, both Indigenous and not, it had its fair share of difficulties in being effective for a variety of other cold cases (McDiarmid, 2019). During the Pickton trial, the VPD and the RCMP were both criticized for deficiencies in their investigations following the claim that the RCMP failed to appropriately investigate Pickton and the VPD failed to hold the RCMP accountable (IACHR, 2014). This occurrence, in tandem with similar investigative misconduct in the Paul Bernardo serial homicide case, led to

federal requirements for police agencies to develop Major Case Management (MCM) procedures. These standard procedures aim to ensure that investigators communicate with one another during cases and have a supervisory system in place to review conduct (Campbell, 1996; Epstein, 2021; Vancouver Police Department, n.d.).

In 2005, the RCMP started *Project E-PANA*, an investigative task force into the missing and murdered women and girls of the Highway of Tears (Carrier Sekani Family Services, n.d.).[8] The first objective was to determine if a serial killer was responsible for the large number of women found murdered along the highway (RCMP, 2016). Cases included in the investigation were small in number, starting with nine young women in 2006 and doubling to 18 cases by 2007. The case criteria for inclusion involved females categorized as 'from a high-risk lifestyle,' who were known to hitchhike (a common practice in rural communities), and were either last seen near Highway 16, 97, or 5 or whose bodies ended up there (McDiarmid, 2019; Rodgers, 2019). The number of cases taken on by the E-PANA task force are long criticized as the number of MMIWG cases that fit the criteria today are well over the number of cases included in their investigation. Contention also exists in that the E-PANA task force has provided more attention to white cases than Indigenous cases as there is a disproportionate number of white cases included in their active case list compared to Indigenous cases.

2.3.4. Lacking Attention

It is best noted here that women and girls are not the only Indigenous people at risk in this circumstance, despite so much attention directed towards MMIWG over the

[8] "PANA is an Inuit word describing the spirit goddess that looks after the souls just before they go to heaven or were reincarnated" (RCMP, 2016, para. 1).

years. Hansen and Dim (2019) argue an important point in that Indigenous men and boys also face a disproportionate risk of harm compared with their non-Indigenous counterparts. Their review of the accessible literature uncovered evidence that Indigenous males experience the highest rate of homicide victimization in Canada (Miladinovic & Mulligan, 2014). They also experience a dismissal of their victim status, like that of Indigenous females, by stereotyping, "including that they are criminals, violent offenders, as well as drunkards and gangsters" (Hansen & Dim, 2019, p. 2). Hansen and Dim argue for an expansion of the overall conversation regarding deaths for missing and murdered Indigenous people and to increase the research and national attention on the community as a whole. I would further suggest that this be applied to Two-Spirit people as well, as there is next to no information available about the missing and murdered Two-Spirit community while research commonly points to an overwhelming risk of harm and violence to gender variant and 2SLGBTQIA+ individuals (Bucik, 2016; Epstein, 2021; Hunt, 2016; Taylor, 2009).

2.4. The Continuous Concern

Even after repeated provincial and national inquiries, a series of recommendation reports, and pressure placed on professional institutions to create effective change, the problem persists in that Indigenous people continue to report that their family members have disappeared or were killed and received minimal or no attention from investigators (McDiarmid, 2019; Nest, Reder, & Bell, 2020; NIMMIWG, 2017; Talaga, 2017). Indigenous people continue to disappear from their homes and families continue to report that police and medico-legal professionals did not investigate the case effectively even after the nationwide NIMMIWG concluded as recently as 2019. These reports come from

across space and time; recent deaths use the newly rejuvenated flame lit by the recent inquiries, while families of victims from older cases, which remained unanswered for years, hoped to finally gain attention to obtain closure. The latter is where my masters research is concerned.

As introduced previously, in 2013, VATJSS, UBCIC, and BCCLA came together to support the families involved with three Indigenous death cases to question the investigations conducted by the RCMP and BC Coroners Service. Each case had been determined as accidental and the investigations were reported to have been brief, despite the suspicious circumstances surrounding each death. These advocacy organizations aim(ed) to support the families in their request for the RCMP to further investigate the three deaths. In 2014, the team invited Palys and ross to further analyze the problem for a critical review of the situation. I was invited to join this project in 2020; this research is my contribution to the longstanding review of each investigation. Grand Chief Stewart Phillip of UBCIC was quoted in an article from *The Northern Review* at the time of the initial local inquiry, reflecting on the significance of the longstanding issue:

> The relationship between many First Nations communities and the RCMP is broken. Time and time again, RCMP action and inaction has made our people feel they cannot rely on them for help and that they will not be treated fairly. The RCMP have not paid enough attention to violent crimes against our people, whether along the infamous Highway of Tears or the many unsolved deaths of women and men throughout the north. We question why the RCMP are so quick to dismiss the suspicious death of Justin Brooks as a suicide or as an accident. We are deeply concerned as to how casually the RCMP approach their investigations when a First Nations person is killed. ("BC Civil Liberties", 2013, para. 4)

2.4.1. Case Context

Before the research design and analysis outcomes are discussed, it is best to first provide the reader with context on the events of how each case came to be, and establish that each victim was a typical young person who was deprived of growing into adulthood with their loving families.

Kayla McKay

There are more questions than answers to what happened on the night of April 12th, 2004, and the three days after.

Kayla McKay was 13 years old when she was taken from her family in a tragic loss of life. She was young, loved, and had a lifetime of experiences yet to be had. Her family last saw her on April 12th in Prince Rupert and, after she had not returned home a day later, her grandparents, who cared for her as their daughter, phoned the local RCMP to report her as missing. They received a not uncommon response: wait, she will probably come home eventually… Kayla did not come home.

At 10 pm on April 15th, The RCMP received a call about a discovered body by the waterfront near the train tracks on George Hills Way. Her body was found face down in the water, missing a shoe. Kayla is now included in the long list of young Indigenous women and girls who died on, or near, the Highway of Tears without answers.

Emmalee McLean

Little is known about what exactly happened the night of April 9th, 2010.

Emmalee McLean (16 years old) had a loving family, a kind heart, and a wild sense of humor. Her aunt recalled how she passed her time with her friends and cousins and still had time to help around the house and look after the younger children. Emmalee was young and had her whole life in front of her.

On the evening of April 9th, Emmalee visited her aunt at her place of work to pass the time until she started her Friday night plans – she had a movie that she talked about wanting to go to around 7 pm. She stayed with her aunt until around 9 pm, claiming she would catch the later show not long after, and drew Hawaiian flowers on everyone's desks before leaving.

The story of the rest of the night gets fuzzy after that. Emmalee ended up at a party with a group of people she knew but were not part of her usual friend group. There was alcohol at the party but how much she consumed is unclear – her aunt mentioned that she had not been drinking over the past couple of weeks and was doing well in life generally. At some point, investigators theorize that she took the short walkway at the waterfront near George Hills Way and climbed up on the big rocks sitting next to it.

The Prince Rupert RCMP received a call at 10 pm the next day about her discovered body partially submerged in the water.

Justin Brooks

The night of March 3rd, 2013 began like any other would for a typical 21 year old young adult just off work with a group of friends.

Justin Brooks' friends and family described him as a kind and gentle young man who was a quiet individual, had a fear of the water, and a tendency to always carry two music players on him in case the battery on one ran out before the end of his shift at the casino. He had a loving family in Prince Rupert, who had a regular tradition of spending evenings with one another, and a newborn son.

On March 3rd, 2013, Justin went to work at the casino in Prince Rupert as usual, his shift due to end around 9 pm. He brought both music players with him to settle through the evening and arranged with friends, who also worked at the casino that night, that they would get together later to have a few drinks. Justin got off work first and agreed to come back by the casino once the others completed their shifts; they met up outside the nearby 7-11 just around midnight. Justin had purchased a bottle of Sailor Jerry's Rum and by the time all three young men were together, they decided to enjoy their drinks at the waterfront. They walked the short distance to sit at a gazebo next to the water just past the large grey whale statue and the Kwinista Railway Station museum.

The three spent a short while drinking and joking with one another before leaving the gazebo to meet up with one of the men's cousins and her friend. They met close by, near the Kaitkatla Ferry Station, and the group decided to return to the whale statue to continue drinking. The five spent an uncertain amount of time conversing there; at some point, the three young men started joking with one another – one teasing Justin about being gay – this went on in a light-spirited nature for a short time, and then the five continued drinking together. The four people with Justin that night could not seem to recall the nature of the conversation past that point but described the events thereafter starting with Justin suddenly "freaking out" for an unknown reason.

Allegedly, Justin and another of the young men got into a scuffle, exchanging blows after Justin reportedly pulled out what was described as a small pocketknife. The third man in the group attempted to separate the two from one another after punches became more severe. One of the girls - both were standing close by observing the fight - picked up Justin Brooks' knife and allegedly threw it in the water. Once the fight ended, the four decided to leave Justin and headed away from the area to eventually get a cab to a local bootlegger and finished the night drinking at a party. Justin was last seen as they left, noticeably intoxicated, loudly swearing, and standing near the railway station without his jacket or sweater on.

A woman walking her dog by the waterfront the next morning discovered Justin Brooks' body in the water and called 911.

Chapter 3. Methods

Countless Indigenous people claim that their loved ones' death investigations were not adequately investigated (McDiarmid, 2019; Michalko, 2016; NIMMIWG, 2017, 2019; NWAC, 2020; Oppal, 2015). The purpose of this comparative multi-case exploratory qualitative study was to examine the integrity of investigative conduct for Indigenous death cases. This was, in part, a hope of contributing academic results to the continuous controversy surrounding Indigenous mortality response in British Columbia. The following research question guided the study to explore the comparative outcomes of three death investigation case studies: How adequately were the three Indigenous death investigations in Prince Rupert conducted when compared with standard investigative procedures? This chapter delves into the specifics of the employed study design, researcher assumptions, and ethical considerations.

3.1. Study Design

This study used a two-part approach to address the primary research question. Due to the restrictive and confidential status of many investigative procedural manuals, the first part involved the development of a standard investigative practice summary based on publicly accessible documentation. In part two, I employed a multi-case study design to compare what was actually done in the three Indigenous death investigations to the investigative standards summary to assess if each case was investigated according to best practice. In support of research dependability, an explanation of both parts come in detail below, including sample composition, data collection, and analysis (Thomas & Magilvy, 2011).

3.2. Standard Investigative Practice Summary

Law enforcement agencies and medico-legal professionals have closed-door policies regarding death investigative procedures to prevent the criminal public from learning how to evade conviction. Standard practice guidelines are thus not readily available to use as a baseline for this research which established the need to create a standard summary based on publicly accessible resources. The goal of this part of the research was to establish a complete, yet general, summary of death investigation procedures from beginning (filing the initial report of death) to end (official closure of the case).

3.2.1. Summary Sample

A thorough investigation of the literature identified that official documentation of procedures required by federal or provincial law was sparse and would require additional credible resources to craft the summary. Resource inclusion followed four primary rules: 1) initial preference went to documents that relayed federal or provincial law for investigative conduct and victim's rights; 2) secondary preference went to international laws mandated either by the United Nations or another common-law system on standard duty in death investigation procedures; 3) official procedural reports created from the recommendation of investigative professionals (to argue that these steps would support best practice); and 4) academic texts used to train investigators.

A purposive sampling technique selected document types with both temporal and geolocational inclusion criteria. Provincial-specific regulations, mandated by law, had a preference in inclusion compared with other resource types, but only the most recent

versions of these guidelines were included for modern analysis. All other resource types had to have been published between 2000 and 2020 to account for both modern practice development and the case study time frame (2004-2015). All resources also either had to be specific to British Columbia or generalizable to North American and/or Canadian contexts. This excluded official standard practice guidelines for law enforcement in other Canadian provinces. All resources included that were not province-specific, had to have some overlap in the agreement of standard procedure for triangulation and validity assurances (Yin, 2014; Zach, 2006).

The standard investigative practice summary came from 13 resources that provide procedural requirements or recommendations for best practice. These resources are discussed in detail below.

3.2.2. Provincial and Federal Policies

The BC *Police Act* (1996) reflects legislation that requires best investigative practice by law enforcement in British Columbia. Procedures in this act are generalized, so as not to give away specific investigative techniques, but lay the foundation for investigative review and police conduct.

The *RCMP Act* (1985), like the *Police Act*, provides the standard duties and responsibilities of RCMP personnel. These procedures focus primarily on maintaining proper officer and investigator conduct and establishing measures to review any reports of misconduct. All RCMP professionals are mandated to follow these procedures in every investigation.

The BC *Coroners Act* (2007) lays the foundation for provincial requirements of coroners in the province. This Act provides the situational requirements for examination of the body during any death investigation and provides specific powers to the coroner during that process.

The BC *Provincial Policing Standards* (2020) guidebook reflects the procedural standards created by law enforcement in British Columbia, under mandate by the Police Act, which provides a detailed description of police responsibilities during an investigation. This guidebook is accessible to the public in a limited fashion; only sections on use of force, police officer training, training courses and development programs, equipment and facilities, and specialized investigations are available, the rest of the document is accessible only by law enforcement professionals.

The *Canadian Victims Bill of Rights* (2015) is the current Canadian Statute to provide victims (including any individual physically or emotionally affected by an event) constitutional rights to information and support during an investigation.[9] The inclusion of this resource in the standard investigative practice summary acknowledges that investigators must be aware of the law and the rights afforded to the families and communities with whom they are working

3.2.3. International Policy

The *Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016)* represents the application of international law on investigative standard practices

[9] The *Canadian Victims Bill of Rights* (2015) follows the previous Statutes: the 1988 *Canadian Statement of Basic Principles of Justice for Victims of Crime,* and the 2003 *Canadian Statement of Basic Principles of Justice for Victims of Crime*.

mandated by the United Nations Human Rights Office of the High Commissioner (UNHROHC, 2017). This resource is a revised United Nations manual created by a team of multi-disciplinary experts in the field of death investigation and other related professions. The aims and scope of the resource provide:

> The Protocol sets a common standard of performance in investigating potentially unlawful death or suspected enforced disappearance and a shared set of principles and guidelines for States, as well as for institutions and individuals who play a role in the investigation. (UNHROHC, 2017, p.1)

Inclusion of this manual in the standard investigative practice summary came from the need to supplement missing BC and Canadian specific protocols with internationally required procedures where necessary. Canada's placement in the UN requires the application of these practices in any death investigation by any investigative role or agency:

> The duty to investigate does not necessarily call for one particular investigative mechanism in preference to another. States may use a wide range of mechanisms consistent with domestic law and practice, provided those mechanisms meet the international law requirements of the duty to investigate … Whichever mechanisms are used, however, they must, as a whole, meet the minimum requirements set out in these Guidelines. (UNHROHC, 2017, p.10)

The sample also included the *Murder Investigation Manual* (2006) produced by the National Centre for Policing Excellence in the United Kingdom (ACPO Centrex, 2006). The manual establishes a detailed investigative guideline for crime scene investigation best practice. This resource was included in the sample as a representative of best practice procedures under British common law traditions and legal rights provided by the Charter of Rights and Freedoms. Any procedures included from this manual had to be informed by general best practice, excluding any practices specific to the UK.

3.2.4. Recommendation Reports

Two editions of the *Death Investigation: A Guide for the Scene Investigator* report were included to represent best practice recommendations made by the National Medico-legal Review Panel (NMRP) in the United States. These reports have support from a wealth of government organization sponsors including the U.S. Department of Justice, the National Institute of Justice, the Centers for Disease Control and Prevention, and the Bureau of Justice Assistance. The NMRP constructed each report, produced initially in 1999 and updated again in 2011, and consists of a multidisciplinary group of experts that have professional experience in death investigation procedure. Their goals were to "identify, delineate, and assemble a set of investigative tasks that should and could be performed at every death scene. These tasks [should] serve as the foundation of the guide for death investigators" (1999, p.1).

Both final reports involved a two-part research design. First, the NMRP surveyed a variety of expert investigators across the United States about minimum standards conducted for every case (1999, 2011). Second, after four rounds of surveying, they compiled the final list of recommended standards under the research tagline *Every scene. Every time*. The application of these U.S. reports in a Canadian investigation review is appropriate insofar as these standards reflect the consensus of experienced law enforcement, medico-legal, judicial, and political professionals on what the baseline standards are for any death investigation in any geolocation. Recommendations come from suggestions of best investigative practice to solve cases, not to account for country-specific political or institutional differences.

3.2.5. Academic Texts

Maloney's *Death Scene Investigation: Procedural Guide* (2018) is in its second edition outlining the methodological steps conducted by investigators for a variety of death circumstances. This academic text systematically summarizes procedures for law enforcement, crime scene investigators, detectives, medical examiners, and coroners throughout the investigation process. The author of this text, Michael Maloney, is an experienced professional in the field with a master's degree in forensic science from George Washington University, "20 years' experience as a special agent with the Naval Criminal Investigative Service and senior instructor at the Federal Law Enforcement Training Center for Death Investigations and Sex Crimes" (2018, p. xxxvii). Maloney's text applies to cases extending outside of the U.S., on a general level, as it reviews best practice for investigative methods. For this research, any U.S. specific methods provided in this text, or any other academic texts, were excluded from the final standard investigative practice summary.

Two texts written by Vernon J. Geberth were included as foundational resources for the standard investigative procedure summary. *Practical Homicide Investigation: Tactics, Procedures, and Forensic Techniques* (2015) is in its fifth edition and is recognized in the law enforcement field as a go-to tool in homicide investigations (Geberth, 2015). While its companion text *Practical Homicide Investigation Checklist and Field Guide* (2014) is in its second edition and "is considered by professionals as an essential prerequisite in conducting proficient death inquiries" (2015, p. xxiv). Geberth has an extensive history in the field with 46 years of law enforcement experience, involvement in over 400 murder investigations, two master's degrees in the field, and

professional homicide and forensic case consultation in the United States and Canada, along with many other qualifications. Both texts train investigative professionals internationally and are a primary educational tool in law enforcement and FBI training. Geberth has had tested success using his methods in Canadian cases; this implies that these standards would be a beneficial addition in this research, despite being a U.S. resource.

The eighth edition of Fisher and Fisher's *Techniques of Crime Scene Investigation* (2012) provides a detailed description of field-tested investigative methods from a forensic science and technology viewpoint. Barry A. J. Fisher and David R. Fisher have a combined 50+ years in the field with specific experience in the forensic sciences and crime laboratory analytics. Their text not only summarizes the best practices for a standard death investigation but also pays homage to the scientific theory and practice required at the scene. Fisher and Fisher's focus on the scientific methodology of investigative best practice provides a generalizable resource that has appropriate application outside of the U.S. into Canada.

Evidence and Investigation: From the Crime Scene to the Courtroom (2019), second edition, provides a detailed review of investigative procedures and evidence collection for valuable application in Canadian courtrooms. The authors, Watkins, Anderson, Bulmer, and Rondinelli, are a variety of experienced professionals from investigative, legal, and scientific realms to inform first-hand successes in these methods to solve cases. The inclusion of this resource allowed for a well-rounded sample of academic texts by serving as the Canadian representation in reviewing investigative standard practices as they apply to Charter and Crown legal requirements.

3.3. Multi-case Study Comparison

The central study design of the research relies on a triangulated multi-case study approach with which to compare to the standard investigative procedure summary. The research goals of this study require an investigation into the reality of the events of each death investigation which plays to the strengths of a case study design: investigating the inner reality of events from the perceptions of those involved (Gillham, 2000). The comparative nature of this multi-case study to standard practice design also resembles a traditional judiciary inquiry which assesses all present evidence and relates it to the issue at hand (CRCC, 2021). Regular inquests into proclaimed unequal investigations often use standard practice comparisons in which to argue that a case had been (in)effectively conducted, suggesting that research would do well to mirror similar designs when assessing related questions and preparing result application.

As mentioned previously, three case studies about Indigenous death investigations in Prince Rupert, BC were the focal point of this research. Each case required an inductive exploration of the events preceding and precluding each death using a variety of data types (interviews, documents, and official reports). Case investigations were then compared to standard procedures for identification of (in)adequate professional conduct. The section below discusses the composition of the sample used in this part of the research, as well as the data collection and analysis phases.

3.3.1. Case Comparison Sample

Three case studies made up the study sample used to compare to investigative standards. These cases were presented to the research team for direct analysis of their

events and thus involved no sampling considerations for case selection (Stake, 1995; Yin, 2014). Each case involved a death investigation for a young Indigenous person from Prince Rupert. A multi-method approach compiled different data types to formulate each case context (Gillham, 2000). This consisted of interviews, case documents, and official investigative records, all provided by the existing research team with permission from the decedents' families. Multiple data types triangulated the information provided about each case investigation.

3.3.2. Case Comparison Data Collection

The research included five semi-structured interviews, including three in-person interviews with the families of each decedent about the nature of each death investigation, and two virtual/phone interviews with former support representatives from VATJSS and BCCLA.

In 2014, Christine Martin and Dr. Ted Palys conducted interviews with the three families in Prince Rupert. Martin fulfilled the role as the family advocate and provided support and case context throughout each interview. Palys asked guiding questions about the events of each investigation informed by the context of his professional background in ethics and Indigenous issues. These interviews came from the relationships built and trust established between the families, Martin and Palys. The nature of the conversations were emotionally difficult for all involved which imposed the expectation that interviews could end at any point and that the families need not feel pressured to talk. The interviews were unstructured, prioritizing conversation over answering defined research questions, and aimed to understand each decedent as a person generally, the events

leading up to their death, the events upon discovering the death, and the investigation process and relationship with police and medico-legal professionals thereafter. The later analysis utilized transcriptions of each interview recording.

I conducted a secondary purposive sample of two interviews, one with Christine Martin and the other with Micheal Vonn, in the winter of 2021. These were conducted to not only connect myself with the events of the investigations years after the research began but also to gain the perspectives of advocacy professionals about the nature of the cases themselves. The inclusion criteria remained general in that interviewees had to have been connected in the preliminary investigation to each case in 2013 and could not be a family member for any of the decedents (for alternative perspectives of events). I selected Martin because of her role as the family advocate and her previous role as the executive director of VATJSS in 2013. I selected Micheal Vonn also for her insight on the legal reviews of the cases in 2013 and her role as the BCCLA policy director at the time. Both interviews occurred virtually (on the phone and through a secure Zoom connection) and included guiding questions about the nature of the three investigations, the relationships the families had with investigative professionals, and concerns or discoveries that each interviewee had at the time of the inquiry. The later analysis used transcriptions of each interview recording.

Upon written approval from each family in 2021, case files collected when they were first challenged for inadequacy in 2013 came from VATJSS (the steward for case information). Documents included the Freedom of Information (FOI) requests made by Martin and Justin Brooks' mother in 2015; situational reviews of case conduct by legal professionals Patterson and Vonn and the BCCLA in 2013; communication receipts

between the families, advocates, law enforcement, and medico-legal professionals between 2013 and 2015; and, for Justin's case specifically, records provided from the private investigator hired by his family in 2013. The sample included all provided documents.

Official coroner reports also were included in the documentation of each case provided by VATJSS upon family approval in 2021. These reports contain the coroner's assessment of each decedent based on autopsy and medico-legal investigation. Reports vary in length and detail depending on the individual case and are representative of the reports that the families received following each investigation. Much of the information provided in these documents was redacted by investigators.

3.3.3. Case Comparison Data Analysis

The analysis involved first, comparing each case investigation to the standard investigative practice summary individually, and second, compiling a total adequacy score by totaling adequate and inadequate attention to procedure for each case. Each case investigation was compared to the standard investigative practices in order of the summarized procedures to determine one of three outcomes: that the selected procedure was either 1) conducted adequately, 2) conducted partially or inadequately, or 3) not applicable. For example, standard investigative practice for BC coroners is to conduct an inquest for all child (18 years or younger) deaths (Coroners Act, 2007). The two cases involving a minor were then examined to see whether an inquest occurred, and if so to what extent. This comparative process continued for every summarized investigative procedure within each case study. Upon completion of the individual case study

comparisons, a further assessment compiled the outcomes of each adequate and/or inadequate investigative procedure conducted to determine the overall proportion of adequacy in each case.

Analysis of individual case study data came in three cycles for data review and refinement purposes (Saldana, 2009). In the first cycle, coding occurred during the first review of case data (interview transcripts, documents, official reports) which compartmentalized the basic structure of each investigation and procedural outcome (i.e., adequate, inadequate, not applicable). The second cycle involved another review of the case data to refine outcome selections for certain procedures or amend previous codes.[10] The third cycle checked for saturation by passing through the data once more without recategorizing (Faulkner & Trotter, 2017).

Each case demonstrated additional investigative procedures conducted by the families that were not included in the standard investigative practice summary (e.g., hiring a private investigator, employing legal representatives, etc.). These procedures were noted in the analysis of the data but were not coded as adequate or inadequate. Rather, they were recorded for discussion on family roles in investigations, particularly in instances of investigator inadequacy for certain procedures.

3.4. Assumptions

The interpretation of the data rested on two logical assumptions. First, the assumption that interview participants would have an adequate recollection of investigation events

[10] Some case procedures demonstrated both adequate and inadequate conduct. This often occurred when procedures were initiated appropriately but had inconsistent follow-through. In these instances, both outcomes were noted followed by a description of the extent of each.

following either personal trauma or prolonged time between events and interview. Documentation of investigative events served as a cross-examination of interview interpretations to maintain summary accuracy. Second, death investigations do not occur in a vacuum, suggesting that other factors outside of the family/law enforcement/medico-legal relationship may impact that process. This may include procedures conducted by first responders, funeral home workers, and/or media that may contribute to death investigation progress but are not within the focus of the research. By restricting the standard investigative practice summary to only law enforcement and medico-legal roles, the case study comparison format enabled a pattern matching design to eliminate external roles (Yin, 2014).

3.5. Ethical Considerations

This research revolved around very personal, and traumatic, events for the target community. Methodological concerns thus required a sensitive and direct approach to account for ethical assurances, protection of those involved, and maintaining the overarching concept of 'do no harm' (Aluwihare-Samaranayake, 2012; Fisher & Anushko, 2008; Sanjari et al., 2014). The primary ethical principles applicable include confidentiality, a duty of care, openness, and reflexivity.

All data included in the analysis contained personal information for each case study decedent and their respective families. Of particular concern in this instance, involving what may be a critical review towards Prince Rupert agencies in power (law enforcement and medico-legal professionals), is that any identifying information of these cases may place those connected at risk of harm (Punch, 2013). Thus, confidentiality and

duty of care for all data were of utmost priority by all researchers. Case files are in the primary care of VATJSS, who acts as a liaison and support network for each case family's well-being. Access to these case documents required open communication with each family, through Christine Martin, where family members were informed of the purpose of the research, the backgrounds of the research team, and an explanation of consent how it may be revoked by them at any time without repercussion. Families also were informed of the intended outcomes (master's thesis, publications, academic conferences) of this research and their right to discuss their preferences with product dissemination at any time were acknowledged. All data transfers between the data stewards and research team remained secure through encrypted communication and storage techniques.

Cowles (1988) notes that particular care should come with research involving sensitive topics, particularly when using interview methods. Interviews with decedent families required open communication of intentions by Martin and Palys as well as explanations of strict confidentiality assurances, informed consent, and the presence of a support advocate (Martin). Martin and Palys gave participants the right to refuse any question asked, all the more important given the sensitive nature of the topic, and they provided further support contacts to the families in case of future concern.

Reflexivity requires discussion as I have an inherently sympathetic viewpoint of the decedents and their communities. Specifically, emotional reflexivity is due in that I have previous experience working alongside Indigenous communities who have challenged inadequate institutional treatment and have lasting connections to that work and perspective. This viewpoint, while seemingly critical towards investigative roles,

allowed me to use my emotional investment to thoroughly investigate the topic. McKenzie (2017) notes that emotional reflexivity is an important methodological resource that uses researchers' connection to their topic to reveal important themes in the data. Additionally, I implemented triangulation measures by including data from sources not provided by Indigenous participants to justify my findings.

The research study received SFU Research Ethics Board (REB) approval under application number: 20160289. This included an academically structured process to ensure participant wellbeing and appropriate preparation to engage in personal interviews about the sensitive topic of death investigation. It was also acknowledged that extra care should come to preparing research with Indigenous people so that the goals and methods align best with the intent to support this community and prevent further harm by colonial assumptions and rigid institutional practices. The research team thus relied on open communication with the families about the intended methods, the personal wellness risks of taking part in this study, and inviting them to review and request edits, changes, and/or removal of content in the results. Families were further informed that the use of their data would go toward this master's thesis, and subsequent academic presentations and/or publications, but I also indicated I would be happy to convey the findings in any local community setting or forum that would be helpful to them.

The relationship of trust established by those involved in the review from 2013 set a precedent for ethical standards unacknowledged by institutional research requirements. The research ethics in this study are informed by the Indigenous relationships, ceremonies, and care transferred to me by the families, the communities, and the research team that uphold this work. Their collective efforts have involved creating and

maintaining decades of trust and understanding without need for signed consent forms or appeals to councils before beginning. The research ethics reflect the community expectation of support and dedication to achieve a common goal. This means that the relationship and duty of care do not end with the publication of this research, but instead continue into lifelong work together towards other areas of injustice.

This research is intended for the benefit of the communities in which the target issue affects most, the Indigenous community of Prince Rupert, the affected families of the three case investigations, and the cause of 'justice denied' into justice fulfilled. The methods reflect that intent by establishing a clear focus to uncover the answers to whether their investigations were adequate or not, and creates an accessible summary of standard investigate practices for communities to use in future claims against investigators.

Chapter 4. Standard Investigative Practice Summary

The non-investigator must rely on piecemeal procedural guidelines, generalized international laws, recommendation reports, and generalized academic textbooks to learn what death investigations should contain. This bears the question: how can a member of the public discern if an investigation was properly conducted? This section will summarize the baseline requirements for death investigations with the acknowledgment that not all practices and procedures are included and that geographical variations may exist. A summarization of basic standards to a complete investigation comes in three stages: duties before and at the crime scene, investigative responsibilities outside of the scene, and check-and-balance policies for conduct review. This chapter will serve as the baseline standard to compare investigation case studies in subsequent chapters. It also exists to inform general basic standards for all death investigations - with hope that others may find it useful should they need it - and thus may summarize some procedures that are not directly applicable to the three case studies in this research.

4.1. Duties Before and at the Scene

Procedures conducted at the beginning of an investigation are arguably the most crucial to get right. Time may damage witness recollection of events and distort or destroy evidence at the scene. Professionals responsible for investigating a death must not only respond quickly but also act systematically for the risk of losing vital case information. This section details the investigative procedures required for a thorough assessment of death from the initial report to documenting and analyzing the body.

4.1.1. Initial Report Intake

The first report of a missing person or death scene can be quick, vague, and yet integral to investigative information. For report intake, either in person or over the phone, the baseline standard is to record as much information as possible (ACPO Centrex, 2006; Geberth, 2015; Maloney, 2018). Standard principles insist that either the emergency phone-line operator or on-duty officer take the matters reported seriously and include the "exact time the call was made, where the occurrence is located, a description of the scene and/or perpetrators, and the name, address and phone number of the reportee" (Geberth, 2015, p. 49).

Additionally, BC *Provincial Policing Standards* provide no room for delay following the initial report of a missing person (British Columbia, 2020). Intake standards are explicit in that all reports must be accepted and that no barriers should inhibit the reporting process including demographics or previous history of the missing person. Subsection 5.1, part two further states that "under no circumstances should a reportee be advised that they must wait a specific period of time before a report can be made" (British Columbia, 2020, p. 128). Immediately following the report, an officer must conduct a risk assessment for the missing individual to determine the resources required for the investigation. For missing persons determined to be high risk, an investigation is immediately assigned to a senior ranking officer and missing persons coordinator and provided appropriate resources.

A case file should be established at this point, which is required to be actively investigated, included in the Provincial Missing Person Intake Form (PRIME) BC

database, and used to continuously inform the family/reportee of the investigative actions taken. “High-risk individuals” include anyone who may be in immediate danger due to any one of these instances:

> (a)Their own vulnerability (e.g., the very young and very old, persons with physical illness, disability, addictions or mental health concerns, persons who may be suicidal and persons involved in activities that may place them at increased risk of harm);
> (b) Being part of an identifiable group that is at an increased risk of harm;
> (c) The weather or physical conditions where the missing person is believed to be; or
> (d) Reasonable grounds to believe they may be the victim of a crime. (British Columbia, 2020, p.131).[11]

The case file for either a missing person or death scene report should contain a record of the transcribed information for later reference. The reportee should be encouraged to remain at the scene, if applicable, until authorities arrive, provided the assumption that this individual may either be the perpetrator or may forget important information after leaving the scene (ACPO Centrex, 2006; Geberth, 2015). They also should be advised to stay out of the primary scene area and to prevent others from entering and contaminating the scene. The intake report should contain the contact information of the reportee should they flee.

4.1.2. Arriving at and Securing the Scene

The crime scene is both the most important location in any death investigation and the most chaotic space to be (Geberth, 2014; Maloney, 2018). A variety of different people will attend in what may be a small, confined space or large, spacious area, including on-

[11] British Columbia (2020) provincial policing standards identify Indigenous women and girls as qualifying under subpart (b): “Being part of an identifiable group that is at an increased risk of harm,” providing this demographic with automatic high-risk status.

duty officers, investigators, medico-legal personnel, families, and stray onlookers. The number of people present, however, can be detrimental to the integrity of the scene and risks destroying evidence or the situational context. This fine line between having the necessary people available to investigate and ensuring the scene remains untampered is why many practical homicide investigation guidebooks lay out a systematic and methodological process for how to control the scene. Although each death investigation is unique and requires different variations of investigative professionals present, the fundamental roles at all scenes are first officers, investigators, and medico-legal representatives.[12]

The first officer on sight has an important duty, upon arriving, to protect and preserve the crime scene and any present evidence. If the professional responsible for receiving the initial report was successful in persuading the reportee to stay at the scene, the officer should ensure that that person remains present for questioning (Geberth, 2014, 2015; Watkins, Anderson, Bulmer, & Rondinelli, 2019). The first officer must also establish scene boundaries, keeping out any people who may interfere with the integrity of the investigation, and record detailed notes of who enters and exits the area (ACPO Centrex, 2006; National Institute of Justice US & United States National Medico-legal Review Panel, 1999, 2011; UNHROHC, 2017; Watkins, Anderson, Bulmer, & Rondinelli, 2019).

[12] For the purposes of this research, "first officer" describes the first on-duty law enforcement officer to arrive at the scene. This person must maintain control of the scene until relieved by an investigator. Medico-legal representatives include any investigative medical professional tasked with tending to the deceased including coroners, medical examiners, or forensic pathologists. Other essential officials may include additional law enforcement, EMS, fire, or social/child services.

The original context of the scene is important for an accurate investigation so officers must be diligent not to tamper with the original state of the area and document everything before investigators or medico-legal professionals remove items (Geberth, 2015; UNHROHC, 2017; Watkins, Anderson, Bulmer, & Rondinelli, 2019). Locard's Exchange Principle indicates the necessity for preserving the original context and potential evidence present at the scene provided that possible perpetrators may have left evidence behind. This includes the insistence that the first officer prevents any non-investigator from entering scene boundaries, including surviving family members. The standard, in this instance, is that "it is still important for the officer to use tact and maintain a professional image" while preventing the family from approaching their loved one or the immediate scene (Geberth, 2015, p. 61). The officer should begin these steps of preliminary crime scene maintenance and documentation while waiting for special investigators and medico-legal professionals to arrive. Requests for these professionals to attend the scene should immediately follow the first officer's arrival and initial determination of death.

4.1.3. Documenting and Evaluating the Scene

British Columbia (2020) *Provincial Policing Standards* use prosecution as an investigation end goal. Standard practices and procedures ensure that if an investigation were to go to court, the proper authorities would already have the necessary case documentation prepared. Thus, investigative professionals, medico-legal or otherwise, must be as thorough and exhaustive as possible when collecting all relevant evidence and information from the scene (UNHROHC, 2017; Watkins, Anderson, Bulmer, & Rondinelli, 2019). Regardless of first impressions, best practice for standard procedure

requires that all suspicious death cases are initially investigated as homicides until proven otherwise (ACPO Centrex, 2006; Geberth, 2015). The National Centre for Policing Excellence explains that "if the potential for these reports to involve homicide is overlooked, opportunities to gather significant material may be lost" (ACPO Centrex, 2006, p. 34).

Before entering the scene boundaries, investigators should identify and document the identities of essential officials and their specific responsibilities to maintain scene safety and record case activity (NIJUS & USNMRP, 1999, 2011; UNHROHC, 2017). The established lead investigator should conduct their own initial walk-through of the scene with more detail and attentiveness than the first officer had previously, given that they should have a more comprehensive background and knowledge in investigative procedure (Geberth, 2015; NIJUS & USNMRP, 1999, 2011; Watkins, Anderson, Bulmer, & Rondinelli, 2019). The expectation for documentation remains the same for the investigator as it did the first officer – they should be methodical in recording all information from the context including scene boundaries, established path of entry and exit, identification and photography of fragile evidence, personal impressions, and impressions/information from the first officer on the scene (ACPO Centrex, 2006; Maloney, 2018; NIJUS & USNMRP, 1999, 2011; UNHROHC, 2017). These detailed notes should be kept by the investigator from the first moment on the scene until the end of their position on the case and should remain with the case files should the investigator transfer out before the case closes.

Investigators should record final notes before other professionals interfere or remove aspects of the scene for their part of the investigation (Geberth, 2014; Watkins,

Anderson, Bulmer, & Rondinelli, 2019). The case file should include a thorough description of the scene and extensive photographs.[13] Notes should include any collection or removal of evidence not previously documented (NIJUS & USNMRP, 2011; UNHROHC, 2017). These measures aim to improve recollection of the scene during future analysis.

4.1.4. Evidence Collection and Management

Upon finalizing the walk-through, the lead investigator should develop a processing plan based on the identified evidence and scene assessment (ACPO Centrex, 2006; Maloney, 2018; UNHROHC, 2017). Careful consideration should account for the theorized manner of death (natural, accidental, suicidal, or homicidal) and any specific priorities associated with it. The UNHROHC (2017) mandates that "all material located at a crime scene should be considered potentially relevant to the investigation," suggesting that investigators should reasonably collect and evaluate all relevant items (p. 14; Fisher & Fisher, 2012; Geberth, 2015). In Canada, *R v Stinchcombe* (1991) requires investigators to collect and preserve all relevant investigative evidence should the case come to court (Watkins, Anderson, Bulmer, & Rondinelli, 2019). This maintains that a failure to collect or preserve evidence

> might constitute an improper use of police discretion, an abuse of process, an obstruction of justice, or a breach of the accused's Charter rights, all of which affect the Crown's ability to prosecute a case. (Watkins, Anderson, Bulmer, & Rondinelli, 2019, pp. 75-76)

[13] Geberth (2014) insists against the deletion of scene records at any point. The case file should include all photographs and information for the duration of the investigation.

All applicable evidence types should be considered for sampling including human biological evidence, non-biological physical evidence, digital evidence, forensic accounting evidence, and soil/environmental evidence (UNHROHC, 2017). To protect evidence integrity, collection procedures must follow specific protocols according to type and circumstance. Special investigators including, but not limited to, sexual assault response teams, entomologists, forensic archaeologists, and/or forensic anthropologists may need to collect additional sensitive evidence (Maloney, 2018; Watkins, Anderson, Bulmer, & Rondinelli, 2019). Great care also should go into safeguarding fragile or easily destroyed evidence such as friction ridges on fingerprints or latent prints, impressions, or lingering residue. The UNHRROHC (2017) provides clear instructions for evidence preservation and protection that all investigators are required by law to follow:

> To minimize forensic contamination and to protect the health and safety of personnel, suitable protective clothing should be worn wherever it is available, including, at a minimum, gloves and masks. To ensure that evidence is preserved, the correct packaging and methodology for each type of evidence need to be used. When resources or logistics do not allow for this, packaging that will minimize cross contamination or the forensic degradation of the sample should be used. (p. 14)

A single facility tasked with protecting and managing items should house all evidence if needed for future evaluation or litigation (Geberth, 2015; NIJUS & USNMRP, 2011). Forensic analysis of all such evidence must be sent to an independent laboratory, which suggests the result of those tests will take time to return to the investigator (Watkins, Anderson, Bulmer, & Rondinelli, 2019). A typical evidence timeline includes the initial collection at the scene by a forensic specialist, intake procedures at a forensic laboratory (packaging, tracking number assigned, logged in official database), evidence assignment to multiple applicable forensic scientists, and

results sent back to investigators. This process may take days to months to complete, depending on the severity of the case, as laboratory workload and availability is often limited. The decedent's personal belongings also should be processed and evaluated with the intention that there will be a future return of such items to the next of kin (Geberth, 2015; NIJUS & USNMRP, 2011). Further search plans at the scene should prioritize locating missing items from the decedent's supposed belongings or items believed to be associated with the circumstance of death (i.e., weapons, illicit drug paraphernalia, prescription or over-the-counter medication, etc.).

4.1.5. Witness Interviews and Canvassing

To contextualize the scene, investigators should interview any present suspects, if applicable (Geberth, 2014, 2015; UNHROHC, 2017). If the first officer took a suspect, or suspects, into custody upon arrival at the scene, the investigator must isolate the individual(s), interview the arresting officer separately for relevant information, request documentation of observations, and ensure that the suspect is given their rights before official interrogation may begin (Geberth, 2015). The case files should include signed documentation of any interrogation and examination of the suspect(s). This also should include a general evaluation of the suspects' demeanor and general profile for later reference.

To reconstruct the events leading up to, and following death, the investigator also should interview potential witnesses in a thorough canvass of the area surrounding the primary scene and any other ancillary scenes (Geberth, 2015; Maloney, 2018; UNHROHC, 2017). Investigators should "allow individuals an opportunity to provide

information that they believe is relevant to establishing the facts" about a death, requiring that no individuals are turned away should they come forward with information (UNHROHC, 2017, p.16). Additionally, investigators should question the decedent's personal community to establish an individual profile including a basis for the circumstance leading up to death, the body discovery history, events when last known alive, and medical, mental health, and social history (NIJUS & USNMRP, 2011). This process is a beneficial investigative practice that may inform risk factors, potential motivations for criminal circumstances, and establish an event timeline. The UNHROHC (2017) provides that "the profile will test the working hypotheses of the case and assist in generating investigative opportunities where other lines of inquiry have been exhausted" (p.15). Investigators must provide extensive notes of this process for the case file to create a working record of who was interviewed, what areas were canvassed, and what still needs to be completed. This step is especially relevant for investigations that contain multiple investigators or replace lead investigators over time.[14]

4.1.6. Documenting and Evaluating the Body

As the central evidence of the investigation, the body should be one of the final items removed from the scene if possible (Geberth, 2014, 2015). According to part two, section five of the BC *Coroners Act* (2007), "the body cannot be moved or altered in any fashion without the authorization of the coroner first. This includes changes made to the immediate environment." This not only requires the presence of a coroner, or other qualified medico-legal professionals, at the scene but also prohibits other investigators

[14] This process of interviewing and canvassing is not for every investigator. Geberth (2015) identifies the standard of carefully selecting personable investigators for the duty, rather than using available personnel arbitrarily.

from altering or removing aspects of the scene until authorized. The BC *Coroners Act* also requires that the first officer immediately request a coroner at the scene for instances including but not limited to:

> circumstances relating to the death of an adult or child who the person has reason to believe has died…as a result of violence, accident, negligence, misconduct or malpractice [or]…suddenly and unexpectedly, when the person was apparently in good health and not under the care of a medical practitioner or nurse practitioner. (2007, 2(1))

Once at the scene, a medico-legal professional will take control of the body to perform an initial external examination (Geberth, 2015; Fisher & Fisher, 2012; Watkins, Anderson, Bulmer, & Rondinelli, 2019). The preliminary analysis of the body must be thorough as the original context of the scene cannot be reinstated. Like that of the scene itself, the body requires photographs with measurement and context for later reference (NIJUS & USNMRP, 1999, 2011; UNHROHC, 2017). The medico-legal professional should record their findings during the external examination of the body and include details about the decedent's physical attributes, relationship to the scene, and possible cause, manner, and circumstances of death. Additional considerations should account for the presence or absence of clothing, body art, signs of injury or trauma, resuscitative efforts, and postmortem changes. Prior to moving the body to another location, any trace evidence found on, or near, the body should also be documented, photographed, and collected. Based on the findings at this phase, the medico-legal professional may request special forensic investigators (i.e. pathologist, odontologist, etc.) or technology to conduct further examinations (NIJUS & USNMRP, 2011; Watkins, Anderson, Bulmer, & Rondinelli, 2019).

While the first officer or investigator may make an initial determination of manner of death or decedent identification, the medico-legal professional must assess the body to confirm or deny such judgments (Fisher & Fisher, 2012; Geberth, 2015). Identification efforts should use a multitude of methods such as personal identification by next of kin or comparisons using DNA, fingerprint, radiographic, and/or dental records (NIJUS & USNMRP, 1999; UNHROHC, 2017). Further identification methods assessing body art, physical characteristic, or anthropologic data may also assist the process depending on the state of the body.

In unnatural or suspicious death investigations, the body will be ordered for further analysis under autopsy in another location (Geberth, 2015; Maloney, 2018; Watkins, Anderson, Bulmer, & Rondinelli, 2019). The UNHROHC (2017) provide that "a decision not to undertake an autopsy should be justified in writing and should be subject to judicial review," should the coroner choose against one (p. 7). Depending on the rate of decomposition and remaining evidence, the prioritization to preserve the original scene context may delay the autopsy request until the scene officially closes. Once the body is removed from the scene, with approval from a medico-legal official, the postmortem examination should involve both external analysis and internal autopsy to determine cause, manner, and circumstance of death (Fisher & Fisher, 2012; Watkins, Anderson, Bulmer, & Rondinelli, 2019; UNHROHC, 2017). The external examination involves a less invasive assessment and record of the deceased's clothing, trauma/injury description, and any associated artifacts found (e.g., insects, medical implants, deliberate mutilation).

The internal analysis follows with a systematic examination of the head, neck, cervical spine, thorax, abdomen, organs, and genitalia – a forensic pathologist must conduct this procedure as it requires specific medical knowledge (Geberth, 2015; Maloney, 2018; Watkins, Anderson, Bulmer, & Rondinelli, 2019; UNHROHC, 2017). This process allows the pathologist, and any reviewing investigator, to reflect on the presence of wounds and/or other notable factors. An official report must include all such findings providing a detailed assessment of the autopsy and the coroner's diagnosis of cause and manner of death. The pathologist should provide an opinion in their assessment about how any injuries may have been caused and whether they contributed to death (UNHROHC, 2017). Geberth insists that medico-legal professionals should give their medical opinion using "simple, understandable English, avoiding medical terminology and indicating the nature of the injury that caused death and any major complicating factors" (2015, p.848).

The BC *Coroners Act* (2007) provides medico-legal professionals with additional powers to request further tests and investigations into the nature of death. Dependent on the information already collected about the decedent, the coroner may order further tests for the final write-up, including toxicological examinations of bodily fluids or organs. The Chief Coroner may also request a Coroners Service Inquest for any death determined as "unnatural." Amongst a list of circumstances that require automatic coroner investigations are deaths in the presence of an officer, child deaths of any nature (ages 18 years and under), or deaths resulting from a dangerous practice or circumstance that the public should be informed about (Coroners Act, 2007).

Open communication between medico-legal professionals, during their examination, and the lead investigator not only benefits the integrity of the investigation but also assists with the speed at which it is completed (Fisher & Fisher, 2020; Maloney, 2018; Watkins, Anderson, Bulmer, & Rondinelli, 2019; UNHROHC, 2017). Processing the scene requires both the investigator to be present at the autopsy, to provide any pertinent information from the primary scene for context, and for the medico-legal professional to be in close communication with investigators in case their discoveries have any immediate impact on the case (Geberth, 2015; UNHROHC, 2017). Further communication of these procedures, albeit more general, should extend to the decedent's next of kin.

4.2. Investigation Outside of the Scene

Completion of the scene investigation does not mark the end of the case. Rather, while the investigator must pursue other leads, assistance to the decedent's family remains important up until, and even after, the case is officially closed (Geberth, 2015; NIJUS & USNMRP, 2011).

4.2.1. Supporting the Surviving Families

The unexpected death of a loved one has no standard reaction. While investigators should be systematic in upholding standard procedures during a case, they must also acknowledge that victims' families do not operate along the same guidelines. Standard support procedures for the bereaved lie primarily with victim service units and liaisons that work either through, or alongside, law enforcement agencies. That aside,

investigators and medico-legal professionals still have important standard duties to fulfill with the families.

Across standard guideline reports and training manuals, the first investigative rule is to give death notifications to the families in person (British Columbia, 2020; Geberth, 2014, 2015; Maloney, 2018). The process of notification, once in the presence of the family, should reflect a balance between providing information, gathering information, and allowing family and loved ones the space to process the death. At a base level, investigators need to provide the family with their identification and contact information and explain, as simply and directly as possible, the initial notification of death and the details of the death circumstances (Geberth, 2014). The investigator should also be prepared to discuss any confirming evidence that led them to the source of positive identification and answer questions in a manner that is truthful but does not jeopardize the investigation. Of significance on the topic of withholding information from the families, Geberth notes:

> In the early stages of the inquiry, there is a tactical and strategic rationale in withholding certain information known only by the police and the murderer. The detective should advise the family accordingly so that they understand why the police do not provide them with all the details. Most persons will accept this explanation early in the investigation. However, what should be noted is that as the case progresses, the family should be provided with as much information as possible. (2015, p. 378)

Although the case information provided to families initially may be limited, international law provides certain assurances to their rights to request specific kinds of information from investigators:

> Family members 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. In cases of potentially unlawful death, families have the right, at a minimum, to information about the circumstances, location and condition of the remains and, insofar as it has been determined, the cause and manner of death. (UNHROHC, 2017, p.4)

These same laws also state that the families must receive frequent updates from the investigator about the progress of their investigation during all phases (UNHROHC, 2017).

Investigators also should collect information at this point in the investigation, including details about the victims' lifestyle and DNA evidence for forensic comparison (Geberth, 2015; UNHROHC, 2017). The family should select a designated individual to identify the deceased at the morgue and either the investigator or the liaison will have transportation arranged for them to do so. It is at this point that they must be informed that an autopsy is required to establish an official cause of death. International law further entitles families "to have a representative present during the autopsy," should they choose (UNHROHC, 2017, p. 9).

Death notification is a fragile and crucial step to the investigative process, requiring investigators to ensure that they are conscious of the psychology of the grief process and express condolences and support in a professional and empathetic manner (Geberth, 2014; 2015). It is the duty of the lead investigator to "also [become] the advocate for the deceased and the surviving family throughout the entire process" (Geberth, 2015, p. 371). Families should be made aware that they can contact the investigator at any time should they have questions or concerns and should have additional support resources and contact information provided to them. They also should be made aware that they have rights to action during an investigation:

> Family members must be enabled by the investigating authorities to make suggestions and arguments as to what investigative steps are necessary, provide evidence, and assert their interests and rights throughout the process. (UNHROHC, 2017, p9)

In BC, *Provincial Policing Standards* emphasize the importance of the families' role in the investigation and provides steps to protect them throughout the process (British Columbia. 2020; Canadian Victims Bill of Rights, 2015). These standards insist that while families may provide beneficial contributions to the investigation, they must also have any wishes for privacy, from the community and media, respected and maintained. Investigators are also required to provide the families with a support liaison who must communicate with both parties regularly to keep everyone informed throughout the investigation (UNHROHC, 2017). International law, as summarized by the UNHROHC (2017), states:

> wherever it is feasible, a specific and suitably trained and experienced family liaison expert should be appointed to offer the family of the deceased information and support as well as to collect the information, such as ante-mortem data, required for identifying a deceased person. The expert should meet the family at the earliest opportunity, should provide regular updates about the investigation, its progress and results, and should address any concerns the family may have as the investigation progresses. A positive relationship with the family of any missing or deceased person can produce useful information and results for any investigation. (p.15)

Medico-legal professionals are also required to keep the family informed of the autopsy results and final determination of cause and manner of death (Bucholtz, Scott, & Prudy, 2015). Part five, section 41(1) of the BC *Coroners Act* (2007) requires that an official record of the medico-legal professional's determination be provided to a representative of the family, either in person or by mail, with valid receipt in a timely manner. This communication with the family should use "lay language of the findings of

the medical analyses" and should include adequate contact information in case they have clarifying questions about the report (Bucholtz, Scott, & Prudy, 2015, p. 10).

Standard investigative guidelines for family support may be sparse compared with other procedures, but the underlying requirement maintains that investigative professionals make themselves accessible, provide clear and timely information, set up contacts with victim service liaisons, and do all this in a professional and empathetic manner. The *Canadian Victims Bill of Rights* (2015) provide many of these procedures as constitutional rights to decedent's families and communities.[15] Section 6 of the Act mandates that families have the right to request information about:

> (a) the criminal justice system and the role of victims in it;
> (b) the services and programs available to them as a victim, including restorative justice programs; and
> (c) their right to file a complaint for an infringement or denial of any of their rights under this Act.

It also gives families the right to know the status and outcome of their investigation and about any progress on judicial proceedings. The value in these procedures for the families and community can be great, especially if investigations have uncertain endpoints.

4.2.2. Cold Cases

The UNHROHC states that "the failure of the State promptly to investigate does not relieve it of its duty to investigate at a later time: the duty does not cease even with the passing of significant time" (2017, p.7). Should a death investigation remain unsolved for quite some time, cold case units must maintain them until successfully closed. Given that many cold cases may exist at once, and continue for a long period, many agencies

[15] The Canadian Victims Bill of Rights (2015) allows any "individual who has suffered physical or emotional harm…" to exercise victim's rights provided in the act (para. 3).

struggle with the number that can be taken on by one investigator at a time. The United States Department of Justice suggests that for any cold case unit, the standard should exist that a single investigator should have no more than five cold cases at any one time and should not be assigned to any other incoming cases or temporary assignments (Barcus et al., 2019).

Cold cases, depending on the length of time they have remained unsolved, and the investigative efforts already employed, can lack direction and structure. Standard guidelines are thus purposefully systematic for investigators to follow. For instance, each case should involve a multitude of investigative roles and agencies to examine the evidence collected (Barcus et al., 2019). The lead investigator should compile a written protocol that organizes individual involvement in each case, what their role and duties are, inform and debrief transitional staff, maintain constant communication with families, and ensure that they have access to support resources. Investigators are also responsible for reviewing new forensic and evidence management procedures as they develop to determine if new practices could be beneficial. Throughout this process, some standards may allow for investigative discretion given the uniqueness of individual cases. To account for this flexibility, cases must have consistent documentation of procedures and maintain regular review of supervisory roles. This serves as a check and balance to ensure that the basic standards are met for each case (British Columbia, 2020).

4.3. Checks and Balances

Amongst the procedural standards created for investigative purposes, there are also standards for ensuring that these processes follow a certain level of expectation. Within

BC, *Provincial Policing Standards* (2020), the *Police Act* (1996), the *RCMP Act* (1985), and the *Coroners Act* (2007) have specific requirements for managing proper investigations. The former states that procedural compliance is required for all

> investigations involving, homicide, missing persons with suspected foul play, found remains, sexual assaults that are suspected to be serial or predatory in nature, criminal investigations of workplace deaths/serious injury/mass casualties, and non-familial abductions. (British Columbia, 2020, p. 159)

The *Coroners Act* further requires that all practices conducted by investigators within the province follow the policing standards set forth. The degree to which each agency fulfills these standards is assessed by mandatory annual reports for each investigation conducted. The BC *Police Act* (1996) mandates that in smaller agencies that do not have their own set of procedural standards apart from the provincial guidelines, the director must establish standards of practice for training cooperation and coordination between departments, evaluate compliance with those standards, make subsequent reports and recommendations for improvement, and make such standards publicly available.

> Any forensic doctor involved in the investigation of a potentially unlawful death has responsibilities to justice, to the relatives of the deceased, and more generally to the public. To discharge these responsibilities properly, forensic doctors, including forensic pathologists, must act independently and impartially. Whether or not they are employed by the police or the State, forensic doctors must understand clearly their obligations to justice (not to the police or the State) and to the relatives of the deceased, so that a true account is provided of the cause of death and the circumstances surrounding the death. (UNHROHC, 2017, p.11)

In BC, the *Coroners Act* (2007) maintains checks and balances for medico-legal professionals to ensure that their conduct is aligned with the international law requirements stated above. Section 46(1) allows for the Chief Coroner, upon the belief that a coroner has not performed their duties appropriately, to either order the same or

another coroner to complete the investigation correctly, or complete the work themselves (Coroners Act, 2007). A coroner may also contest or alter a determination for cause of death should they disagree with the result posed by a forensic pathologist. This situation may also allow said coroner to request an Inquest, even if the circumstance of death does not align with the requirements of unnatural death normally followed.

Officer and investigator conduct have additional specific standards within the BC *Police Act* (1996) and the *RCMP Act* (1895). Section 33 of the *Police Act* (1996) requires local police to maintain a "good relationship" with the residents over whom they have jurisdiction. They must also report any instances of inadequacy to the minister, provincial police force, and other designated policing units. Section 77 (3) further categorizes neglect of duty as misconduct which includes the failure to "promptly and diligently do anything that it is one's duty as a member to do." The *RCMP Act* (1895) provided similar conduct requirements for its officers, stating in section 37, that "It is the responsibility of every member … to perform the member's duties promptly, impartially and diligently, in accordance with the law and without abusing the member's authority." The act allows civilians to submit formal complaints against any RCMP officer who does not uphold their standard responsibilities under section 45.53 (1), which may lead to an official review into the inadequate conduct by the Civilian Review and Complaints Commission (CRCC).

These checks and balances provide clear measures for accountability assurances for BC investigators, requiring that they uphold their core duties and can be subject for review should they fail to do so. International law, however, fills an important gap in these procedures by mandating that the public, namely the decedent's families, have

access to the information and judicial support to incite these checks and balances when necessary.

> Family members of victims of unlawful death have the right to equal and effective access to justice; to adequate, effective and prompt reparation; to recognition of their status before the law; and to have access to relevant information concerning the violations and relevant accountability mechanisms. (UNHROHC, 2017, p.4)

This standard, mandated by the international powers of the United Nations, provides an important mechanism for all families to challenge investigator misconduct and to have all the necessary information and support provided to them. It is by this same entity that also requires investigator transparency about "the existence of an investigation, the procedures to be followed in an investigation, and an investigation's findings including their factual and legal basis," to the general public and the decedent's families (UNHROHC, 2017, p.8).

Chapter 5. Results

> *Children usually do not die before their parents, and parents usually do not have to bury their children.* (Geberth, 2015, p. 374)

5.1. Investigative Procedures Assessment

In this section, each case investigation is segmented into the procedural steps outlined by the standard investigative practice summary in chapter four. The assessment will identify each conducted step, the (in)adequacy of that conduct, and any discussion or considerations about those relationships. Each section includes a reference table of standard practice expectations and the adequate and inadequate procedures conducted in each case. Certain standard investigative procedures outlined in the summary could not be assessed because of gaps in the available data, and thus were excluded from the discussion (and indicated as '-' in the reference tables). Some procedures covered in the summary also were not applicable to all three cases (e.g., missing persons reporting only applied to Kayla McKay's case), these are indicated as "N/A."

5.1.1. Initial Report Intake

Standard Investigative Practices	Conduct in Kayla McKay's case	Conduct in Emmalee McLean's case	Conduct in Justin Brooks' case
Initial report intake			
Report taken seriously: no delay in response and record of report	-	Adequate: Police arrived on scene	Adequate: Police arrived on scene Inadequate: Police took an hour to arrive
Reportee informed to stay off scene and prevent others from	-	-	Inadequate: Reportee allowed another person to

Standard Investigative Practices	Conduct in Kayla McKay's case	Conduct in Emmalee McLean's case	Conduct in Justin Brooks' case
Initial report intake			
entering			attempt to retrieve the body
Missing Persons Report: immediate response and risk assessment	Inadequate: Family told to wait 24 hours	N/A	N/A

Table 5.1 Adequate and Inadequate Initial Report Intake Procedures Conducted for all Three Cases

Access to the initial report files is restricted within the RCMP's holding, something that advocates at Vancouver Aboriginal Transformative Justice Services Society (VATJSS) had attempted to gain through a Freedom of Information (FOI) request in 2014. What was available, however, were the recollections of the events by the families themselves and witness testimonies included in a written review by the then-legal advisor to the BC Civil Liberties Association (BCCLA). Adequacy, by standard investigative practice guidelines, requires the RCMP to respond to each death scene report promptly and seriously as witnesses call them in. As a bare minimum, the RCMP did just that by arriving at each scene after the discovery of Kayla McKay, Emmalee McLean, and Justin Brooks' bodies.

Unfortunately, adequate conduct for report intake ends there. In the interview between the family's private investigator (PI) and the woman who discovered Justin Brooks' body, she claimed: "that it took the … police almost an hour to go to the waterfront." This suggests a less-than-prompt response from the RCMP following the initial discovery report for Justin Brooks' remains. Meanwhile, as she waited, another passerby attempted to pull Justin's body from the water, possibly contaminating the crime scene while doing so, and suggesting that she had not been informed to prevent others from entering the scene as is required (ACPO Centrex, 2006).

In Kayla McKay's case, there was an additional element in that she was reported as missing by her grandmother when she did not return home the day after she went out. When her grandmother called the RCMP to express her concern she was told that Kayla had to be missing for 24 hours before they would act in an official missing persons investigation. This is inconsistent with BC *Provincial Policing Standards* (2020) which state that "under no circumstances should a reportee be advised that they must wait a specific period of time before a report can be made" (British Columbia, 2020, p. 128). Further, the investigators should have immediately conducted a risk assessment for Kayla as she was part of a high-risk group identified by the provincial government due to her Indigenous background and young age. The discovery report of Kayla McKay's body came two days after her grandmother tried to claim her as missing.

5.1.2. Arriving at and Securing the Scene

Standard Investigative Practices	**Conduct in Kayla McKay's case**	**Conduct in Emmalee McLean's case**	**Conduct in Justin Brooks' case**
Arriving at and securing the scene			
Section off and secure crime scene	-	-	Adequate
Document original scene contexts	-	-	-
Prevent civilians from entering the scene	N/A	N/A	Adequate
Request professional investigators to attend the scene	Adequate: Coroner	Adequate: Coroner	Adequate: Coroner

Table 5.2 Adequate and Inadequate Arriving at and Securing the Scene Procedures Conducted for all Three Cases

As with that of the report intake information, little is known about the procedures conducted at the scene due to the denied access of information or comment by the RCMP. For Kayla McKay and Emmalee McLean's cases, their families did not attend the

scene, nor were they informed by witnesses or news coverage about how investigators secured the area. Justin Brooks' family, however, did attend the scene after reports of a sectioned-off death scene and a found body at the waterfront had shown up on the news.

Although a difficult procedural step for Justin Brooks' family, the officers at the scene did as required by investigative standards by not allowing them to approach his body. Their doing so prevented potential further contamination of evidence following Locard's Exchange Principle, though this may already have occurred when the unknown man attempted to pull the body out of the water himself. How the officer prevented the family from interacting with the body is unclear. Geberth (2015, p.61) insists that they "use tact and maintain a professional image" while doing so - but the interaction did leave the family with more questions than answers: "and at that point I still didn't believe that it was him because we didn't get to see him" (Justin Brooks' mother). In all three cases, the first officer performed the adequate duty by alerting the coroner to attend the scene for further analysis of the bodies.

5.1.3. Documenting and Evaluating the Scene

Standard Investigative Practices	**Conduct in Kayla McKay's case**	**Conduct in Emmalee McLean's case**	**Conduct in Justin Brooks' case**
Documenting and evaluating the scene			
Assumption of homicide until proven otherwise; investigate to prosecution standards	-	-	Adequate: Initial investigation of foul play at scene Inadequate: Assumption of homicide did not last for thorough investigation
Establish lead	-	-	-

Standard Investigative Practices	Conduct in Kayla McKay's case	Conduct in Emmalee McLean's case	Conduct in Justin Brooks' case
Documenting and evaluating the scene			
investigator; record professionals on scene and their conduct			
Investigator walkthrough and extensive note-taking of scene context for later record	-	-	-

Table 5.3 Adequate and Inadequate Procedures to Document and Evaluate the Scene for all Three Cases

Without knowing the extent to which investigators documented their walkthrough of each scene, there are a few points about their intentions and determinations noted in the accessible data. As noted in the standard investigative practice summary, BC *Provincial Policing Standards* (2020) expects that all investigative procedures will support prosecution. This requires investigators, as further supported by Geberth (2015) and the National Centre for Policing Excellence (ACPO Centrex, 2006), to start each suspicious or unnatural death investigation with the assumption that it was a result of foul play or homicide. Reflections on the events surrounding Justin Brooks' investigation suggest inadequacy in this regard as the case was quickly determined to be a suicide before the necessary investigative steps were conducted to confirm that. Justin's mother commented that investigators called the manner of death a suicide the day after he was pulled from the water and acted in a manner that suggested the case had been closed at that point, an assumption which the media were quick to portray as well. This quick determination came before Justin's body had been sent for autopsy and before a private investigator, hired by the family six months later, uncovered additional evidence that the RCMP had not collected. The determination also came before the coroner, who has

ultimate authority to make the final determination, could conduct her examination of Justin's body.

When Justin Brooks' investigation went under review by the BCCLA, Micheal Vonn noticed a lack of investigative rigor in the case, especially at the scene. A rumor in the community existed that when the coroner arrived at the scene one of the officers yelled the equivalent of 'another accidental death Joe,' suggesting a presumptive detachment that would inform why such a quick decision could have been made. Justin's case, not long after, received a change in determination as accidental slip-and-fall and then again to drowning, but at that point, the window for many vital investigative steps had already closed.

5.1.4. Evidence Collection and Management

Standard Investigative Practices	**Conduct in Kayla McKay's case**	**Conduct in Emmalee McLean's case**	**Conduct in Justin Brooks' case**
Evidence collection and management			
Develop evidence processing plan; collect and evaluate all relevant items	Adequate: DNA collection from family	Adequate: Collected clothing, jewelry, CCTV footage	Adequate: Collected clothing, iPod, keys, wallet Inadequate: Uncollected/unaccounted knife, MP3, CCTV footage, phone messages
Specialized evidence collection, if necessary	Adequate: Sexual Assault Kit	Adequate: Sexual Assault Kit	-
Establish evidence steward facility; housing for future evaluation and/or litigation; plan for return to families upon case closure	Inadequate: No return of clothing after case closed	Inadequate: No return of clothing after case closed	Inadequate: Returned clothing before forensic analysis

Standard Investigative Practices	Conduct in Kayla McKay's case	Conduct in Emmalee McLean's case	Conduct in Justin Brooks' case
Evidence collection and management			
Forensic analysis of evidence to independent laboratory (assume evidence timeline)	Adequate: DNA testing evaluation; return of grandmother's brush	-	Inadequate: Assumed no forensic analysis of clothing (returned too quickly for evidence timeline)
Establish additional search plans for missing items	-	-	Inadequate: Case required an aquatic search for missing evidence

Table 5.4 Adequate and Inadequate Evidence Collection and Management Procedures Conducted for all Three Cases

Evidence collection procedures were inconsistent across all three cases. Investigators followed initial standard practices by considering some elements attached to the circumstances of the scenes. This included appropriately collecting surveillance camera footage from the local 7-11 to observe where Emmalee McLean had been the night before, requesting Kayla McKay's toothbrush and her grandmother's hairbrush for DNA comparison for identification, and retrieving most of Justin Brooks' belongings from the scene such as his discarded clothing, keys, wallet, and iPod. Additional considerations also allowed for sexual assault assessments for both Kayla and Emmalee, provided the suspicious circumstance they were found in, but it is unclear who conducted them.

The processing of Justin Brooks' belongings is inconsistent with the standard evidence timeline for adequate forensic analysis. Justin's clothing, which was likely bloodied from his fight the night before his death, was returned to his family by the police the day after he was found. Standard practice guidelines require that the facility tasked with protecting and managing evidence house it until requested for future

evaluation or litigation. This would suggest that, since Justin's case was not officially closed the day after he was found, no evidence should have been returned to the family at that point (Geberth, 2015; NIJUS & USNMRP, 2011). Furthermore, Watkins, Anderson, Bulmer, & Rondinelli discuss that forensic analysis takes time due to a variety of factors out of the investigators' control, explaining that "the results of those tests might be available to the investigator within days, but more often it takes weeks, or sometimes months" (2019, p.74). It is thus unlikely that Justin's clothes would have received adequate forensic analysis which may have been helpful to contextualize the case.

Kayla McKay and Emmalee McLean's families, on the other hand, did not receive the girls' clothing back from investigators despite the official closure of both cases. Investigative standards provide that the decedent's personal belongings require processing and evaluation with the intention that there will be a future return of such items to the next of kin (Geberth, 2015; NIJUS & USNMRP, 2011). So, when both girls' cases were officially closed by police, and no efforts to open them again occurred in the years following, it would be within good reason to return the belongings to the families. Kayla's grandfather reflected on the absence of the returned items ten years after the closure of her case, stating that it contributed to his disbelief that it had been his granddaughter at all: "we don't even know if that was her clothes that they have."

Evidence collection in Justin Brooks' case had additional concerns of inadequacy especially as investigators were quick to label the death a suicide within the first 24 hours. Given the nature of the events leading up to Justin's death the night before and the fact that he had been found in the water, best practice requires that further search plans should have occurred in the water to locate missing items from the decedent's belongings

(Geberth, 2015; NIJUS & USNMRP, 2011). This would suggest the addition of an aquatic search to locate the pocketknife, that was reportedly thrown in the water, and the second MP3 player, that Justin always had on him, neither of which were recovered by police. It is unclear if the RCMP did conduct an aquatic search for evidence attached to Justin's death as access to case files remains restricted due to the still-open investigation eight years later.[16] What is clear is that, by Justin's mother's testimony, the police had unspoken ideas about the knife which they tested when both parents went down to the detachment to retrieve Justin's ID for the funeral service:

> Me and my husband walked in and we told them who we were and [redacted], she is the female cop, and another guy I don't know ... they both came up with bags … the wallet, [iPod], and keys she gave to my husband and the other guy that was standing in front of me, he took a knife out of the bag, put it on the desk or whatever there, and he just stood there and looked at me like he wanted me to grab it. And I wasn't gonna touch it because I didn't know whose one it was. It was a … knife about that big, with a black handle, and a silver blade and it wasn't a fold one it was not like a … hunting knife and I didn't touch it and we were just standing there staring at each other for a good minute or two and he took it, put it back in the bag, and took off. (Justin Brooks' mother)

Justin Brooks' family never did figure out the police's intention with the knife, especially as it did not match the pocketknife described in witness accounts, but one thing the family did determine is that there was other evidence that the police did not collect appropriately.

Multiple standard practice resources insist that investigators collect "anything and everything" when it comes to possible sources of evidence for evaluation (Geberth, 2015, p. 215; Fisher & Fisher, 2012; UNHROHC, 2017). However, when the PI hired by

[16] It remains unclear why Justin Brooks' case is still open when the coroner deemed it an accidental drowning in 2013. It also is questionable why information was not made available to the family when the case was closed many times, before being opened again.

Justin's family started to look into the local area, they uncovered that 7-11 CCTV footage had not been collected by the RCMP during the initial investigation. Justin Brooks' mother reflected that when the PI went to collect the tapes from the convenience store, after the case had been open for six months, "they said 'no we don't have it. The RCMP came in yesterday and took it." All the while, the family had been requesting for the RCMP to retrieve video footage from local businesses to see if they could help with the case. Additional evidence came to light when members of the family received concerning text messages from someone they knew, claiming that he had beaten Justin and that he had his MP3 player, even though the missing device was never acknowledged publicly. When images of those texts were presented to the RCMP they received a dismissive response in that they would get around to it eventually. As indicated in *R v Stinchcombe* (1991), investigator failure to collect or preserve evidence might constitute an abuse of process and an obstruction of justice (Watkins, Anderson, Bulmer, & Rondinelli, 2019).

Both Kayla McKay and Emmalee McLean's cases went to Crown Council on the recommendation of Criminal Negligence for the two suspects associated with each girl's death. The resulting outcome for both cases, however, is that the Crown advised that there was "no substantial likelihood of conviction" given the lack of evidence. The family advocates at the time raised many concerns thereafter that the lack of evidence may have been because the investigators were not thorough enough in their collection methods.

5.1.5. Witness Interviews and Canvassing

Standard Investigative Practices	Conduct in Kayla McKay's case	Conduct in Emmalee McLean's case	Conduct in Justin Brooks' case

Witness interviews and canvassing			
Interview suspects present at the scene: evaluate demeanor and include signed documentation	Adequate: Suspect interviewed at hospital Inadequate: Suspect allowed to leave town without follow up in Vancouver	Inadequate: Suspect allowed to leave town without follow up in Vancouver	Adequate: Interviewed suspects in "white truck"
Canvass the area surrounding scenes; interview potential witnesses	Adequate: Interviewed party attendees	-	Adequate: Interview friends present at night of death Inadequate: No canvass of the area; rejected witness information
Interview decedent's personal community and family for personal history	-	Inadequate: Did not interview family for profile	Inadequate: Did not interview family for profile

Table 5.5 Adequate and Inadequate Witness Interviews and Canvassing Procedures Conducted for all Three Cases

There were many people present in the events where Kayla McKay, Emmalee McLean, and Justin Brooks were last known alive. Kayla was at a party with approximately 40 other teens, Emmalee was also at a party with a group of people, and Justin was drinking with four friends. These potential witnesses, amongst many other stray onlookers and local shop employees, would make for ideal people for investigators to interview to contextualize each case. Following Kayla and Emmalee's deaths, investigators began interviewing associated people in one form or the other.

When Kayla McKay's body was found, a young man was lying next to her and had attempted suicide by slitting his neck. First responders took the young man to the hospital where he recovered, and investigators conducted appropriate procedures by questioning him as a suspect. While the transcripts of the interview are unobtainable from

the RCMP, investigators did inform the families that their evaluations of the suspect, and his suicide attempt, was not related to Kayla in any way and thus did not take him into custody. Once the boy was well enough to leave the hospital, his father moved them out of Prince Rupert and he was no longer reachable for an interview in the case.

For Emmalee McLean, the BCCLA identified that "the RCMP had interviewed everyone who was at a party that Emmalee attended on the night of her death and had a strong person of interest in the case." Conducting interviews with each member of the party was an adequate effort for police to understand the events of the night of Emmalee's death, and was even successful in uncovering a prime suspect, however, that suspect was unable to be interviewed or detained as he reportedly left town the very next morning. "Yeah, so 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" (Emmalee McLean's aunt).

The instances in which the primary suspects were allowed to leave Prince Rupert fails to acknowledge Major Case Management (MCM) procedures in the BC *Provincial Policing Standards* (2020) that require investigators to establish communication across policing jurisdictions. MCM procedures are a pertinent standard for police to comply with as their development came out of the 1996 Campbell report. Justice Campbell uncovered police failure to communicate was but one of many of the primary reasons the Bernardo serial homicide investigation was unsuccessful and thus required every police department to establish MCM guidelines and follow them accordingly (Vancouver Police Department, n.d.).

The standard investigative practice summary stated that investigators should interview potential witnesses in a thorough canvass of the area surrounding the primary scene and any other ancillary scenes (Geberth, 2015; Maloney, 2018; UNHROHC, 2017). Justin Brooks' death occurred at the waterfront where many residential homes sit close by, overlooking the sea. This was one of the first places his family went to start asking questions door to door, only to find out from one resident that the RCMP had never come by to interview her. She told Justin's mother that she usually hears things at night from the waterfront, but had not noticed anything from that night, even when Justin would have been in a physical fight with one of his friends that evening. Justin Brooks' mother inquired further, "we asked her if the cops been by talking to people and she said 'no, nobody… You're the first ones.'" The family's PI later went back and canvassed the area again, including the businesses Justin and his friends visited - which motivated the RCMP at that point to retrieve the 7-11 camera footage - and interviewed the friends about that night. Many of these people claimed that they would give their testimonies of that night under a polygraph, a service that the Prince George detachment said they could provide. The family advocate inquired about setting this in motion but had difficulty with the local detachment: "we ask[ed] them about getting … lie detector test equipment down - Prince George already said that they would do it, they just have to request it from Prince Rupert – [they] never requested it."

This was not the only interview information that the local RCMP failed to collect. Two separate people contacted Justin Brooks' family, and the advocacy teams looking into his investigation, with concerns that they had attempted to call in information about what they had witnessed that night but were told that police did not need their statements:

> I know of another lady that phoned in trying to help out and she … actually found me in Simpson 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.' (Justin Brooks' mother)

This is inadequate by international standards provided by the UNHROHC (2017) in that investigators must allow any and all individuals to submit information that they believe is relevant to the case.

Interview inadequacy continued at this point in the investigation as police did not question the personal communities and families about decedent profiles or histories. This process allows investigators to determine risk factors, possible motivations for criminal circumstances, and establish event timelines (NIJUS & USNMRP, 2011; UNHROHC, 2017). Without them, important relevant information may be left out of the case context. For instance, when investigators were first considering suicide as the manner of Justin Brooks' death, an interview with his mother would have uncovered his fear of the water (this is the same for Emmalee McLean whose aunt also was not asked about her fear of the water). The UNHROHC (2017) states that victim profiles should test the working hypotheses that investigators may have and open opportunities for other avenues to consider. Advocates questioned investigators as they changed their determination to accidental slip-and-fall for Justin, asking if they had interviewed his mother about the likelihood of such events. They had not.

5.1.6. Documenting and Evaluating the Body

Standard Investigative Practices	Conduct in Kayla McKay's case	Conduct in Emmalee McLean's case	Conduct in Justin Brooks' case

Documenting and evaluating the body			
Coroner has control of the body; only professional that may authorize removal or altering	-	-	-
Preliminary external examination of the body on scene; documentation of original context	-	-	-
Medico-legal professional must examine the body before investigators establish manner of death	-	-	Inadequate: Investigators made claims of suicide and slip-and-fall before coroner determination of drowning
Identification efforts conducted	Adequate: DNA confirmation and biological parents requested	Adequate: Biological parents requested	Inadequate: Mother not allowed to confirm identity
Autopsy off-scene required for suspicious or unnatural deaths; family informed	Adequate: Autopsy in Vancouver	Inadequate: Family unaware if an autopsy was conducted	Adequate: Autopsy in Vancouver
Investigators present at autopsy/body examination	-	-	Adequate: Multiple investigators at autopsy
Coroner's report uses accessible language and includes all findings from body examination; include explanation/ communication of injuries and findings	Inadequate: No report received or explanation of findings	Adequate: Summary of coroner's findings provided; open communication with family Inadequate: Report missing explanation for bruising	Adequate: Summary of coroner's findings provided Inadequate: Report missing explanation for injuries; no communication with family
Coroner may order additional applicable tests for examination	-	Adequate: Toxicology	Adequate: Toxicology
Coroner may	Inadequate: No	Inadequate: No	N/A

Standard Investigative Practices	Conduct in Kayla McKay's case	Conduct in Emmalee McLean's case	Conduct in Justin Brooks' case
Documenting and evaluating the body			
recommend for official inquiry (required for minors)	inquiry for minor-related death	inquiry for minor-related death	

Table 5.6 Adequate and Inadequate Procedures to Document and Evaluate the Body Conducted for all Three Cases

There was a fair amount of adequate conduct on behalf of the local coroner regarding the tests performed on each body. Investigators appropriately requested the coroner at each scene given that the BC *Coroners Act* (2007) requires their presence in violent, accidental, or negligent death circumstances for children or adults normally under good health. The coroner sent both Kayla McKay and Justin Brooks' bodies to Vancouver for autopsy given the suspicious presence of injuries. Emmalee McLean's case was ruled death by accidental drowning, which would suggest an internal autopsy for confirmation, however, her family is uncertain if she had an autopsy which is the job of the coroner to communicate to them. During the initial examination of Justin Brooks' body in Prince Rupert, his mother noted that she found out that the RCMP was in the morgue with the coroner, much to her disappointment as she had still yet to see her son, which supports standard practices in that both investigative roles consulted with one another to improve the integrity and speed of the investigation.

Additional examinations included sexual assault and toxicological assessments. In Kayla McKay and Emmalee McLean's cases, both received examinations to determine whether there had been a sexual assault, though it is still unclear which professional conducted these assessments and if discovered DNA was isolated and checked appropriately. The BCCLA review indicates that toxicological reports revealed

"moderate to high" and "outstanding" blood alcohol levels for Emmalee and Justin respectively, though the BCCLA also only indicated that the "BC Coroner's Service ruled the death accidental by acute alcohol ingestion" for Kayla's case without mention of an official toxicological examination.

Standard investigative practice guidelines require that the coroner communicates with the families about the procedures conducted and that their final report includes simple and accessible terminology (Geberth, 2015). There were instances of both adequate and inadequate conduct across cases for this step. Emmalee McLean's aunt had a generally positive experience of personal communication with the local coroner. She recounted that the coroner called her a few times in the year following the investigation "to ask questions or to tell me that they're still looking into it and that they haven't forgotten." The coroner also went through the official report with her over the phone and explained how she came to her conclusion. The report was sent to Emmalee's aunt a year and a half later and did not explain the presence of the bruising. This is inconsistent with UNHROHC (2017) international standards which insists that the medico-legal professional in charge of examination provide their opinion in the final report on the presence and potential causes of any injuries present.

Kayla McKay's family tried for quite a while to get in touch with the coroner to ask questions about the investigation; they knew she had been sent to Vancouver for autopsy but had not been able to see her body and still were not sure if it was their granddaughter at all. When her grandfather finally got into contact with the coroner, he commented: "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 silence of the coroner was deafening, the family had not received an explanation of the procedures conducted, nor a copy of the coroner's report to go over. Their only information was that the case had been closed and determined accidental acute alcohol ingestion without their prior knowledge.

Justin Brooks’ mother experienced even greater detachment from the coroner as the report came through the mail without so much as a phone call to accompany it. It is significant in that the initial coroner’s report went under review, as the first release date was extended another five weeks when the family questioned the coroner’s determination, and that Justin’s body went to Vancouver for autopsy for further analysis. This represents a shred of adequate forethought considering that the BC *Coroners Act* (2007) grants medico-legal professionals the power to contest death determinations and order additional tests for the body. Where inadequacy sets in, for Justin Brooks’ case, is that after the final report arrived in the family’s mail, the coroner, or any other qualified medico-legal professional, never explained the results to them. “So that's how the coroner let them know … sticking a report in the mail. No contacts behind it. No opportunity to ask any questions” (C. Martin, 2014).

The family’s ability to ask the coroner questions about the final report allows those affected to understand how determinations were made, the meanings behind medical terminology and findings, and for clarifying questions to be answered to avoid future misunderstandings (Scientific Working Group for Medicolegal Death Investigation, 2012). This communication would have been helpful for Justin Brooks’ family to have with the coroner as the mailed report required these clarifications. The coroner performed adequately by summarizing the autopsy findings into a succinct

statement on the final determination of death, however, this statement may have been too brief. The report summarizes that the postmortem examination unveiled that the cause of death was drowning and acknowledged that blunt force injuries were found on the body, but the pathologist could not determine where they were from. The family holds reservations for the cause of death, given the suspicious circumstances presented in witness interviews, but had they been provided a clearer explanation of the cause and manner of death there may have been a better understanding on how the pathologist made their decision. The autopsy report shows presence of bilateral pulmonary edema and foam in the lungs, both of which are consistent with drowning as a cause of death (Erskine & Armstrong, 2021). What can be contested, however, is the manner of death, which the coroner determined was accidental, which is circumstantial to the events that lead to the drowning and suggests the need for a more thorough investigation into the mysterious blunt force injuries.

Amongst all the procedures conducted by the coroner to examine and evaluate the bodies, there is inadequacy also in the steps not performed. The BC *Coroners Act* (2007) requires the Chief Coroner to request a Coroners Service Inquest for any unnatural death, something that arguably applies to each case, but also requires automatic inquest investigation into any child death for those under the age of 18. Neither Kayla McKay nor Emmalee McLean's case went under inquest despite the fact that they were 13 and 16 years old. This procedural inadequacy is both known to the families, as they are unaware of any recommendation for inquest for the two girls, but is also public knowledge, as no inquest reports exist in the BC Coroners Service website database where all cases must be accessible.

5.1.7. Supporting the Surviving Families

Standard Investigative Practices	Conduct in Kayla McKay's case	Conduct in Emmalee McLean's case	Conduct in Justin Brooks' case
Supporting the surviving families			
Death notification in-person: provide brief details and investigator contact information	Adequate: Notification in-person	Adequate: Notification in-person	Adequate: Notification in-person Inadequate: No contact info provided
Investigators should discuss confirming evidence and answer questions	Adequate: Investigator showed family the scene Inadequate: No communication about evidence or progress	Inadequate: Investigator stopped communicating with family	Adequate: Investigator spoke with family at the scene Inadequate: Family had to force communication; police would not answer questions
Families informed of autopsy if applicable	Adequate: Family informed	Inadequate: Family not informed	Adequate: Family informed
Family selects representative to identify the body	Adequate: Police contacted biological next of kin to identify Inadequate: Grandparents unaware of positive identification	Adequate: Police contacted biological next of kin to identify Inadequate: Aunt unaware of positive identification	Inadequate: No member of the family was allowed to identify the body
Families provided support resources and liaisons; police must communicate with liaisons	Adequate: Victim services provided to family	Adequate: Victim services provided to family	Inadequate: No victim services provided to family

Standard Investigative Practices	Conduct in Kayla McKay's case	Conduct in Emmalee McLean's case	Conduct in Justin Brooks' case
Supporting the surviving families			
Medico-legals must provide a copy of the coroner's report and contact information for later questions	Inadequate: No coroner's report provided to family; family had to contact coroner after case was closed	Adequate: Family spoke with coroner about report; Coroner checked-in multiple times Inadequate: Received report after a year and a half	Adequate: Received coroner's report in the mail Inadequate: No contact with coroner for explanations or answers
Family provided access to basic investigation information and progress	Inadequate: Investigators waited two years to speak with family; family unaware of investigative procedures conducted	Inadequate: Family unaware of investigative procedures conducted	Adequate: Approved FOI request for coroner files Inadequate: Family denied FOI request for investigative files; police silence

Table 5.7 Adequate and Inadequate Procedures to Support the Surviving Families Conducted for all Three Cases

Death notification is arguably the most crucial step to conduct according to standard investigative practice guidelines as police attempt to ensure the wellbeing and support of the families in devastating circumstances. Investigators did well at this point when delivering the death notification to Kayla McKay and Emmalee McLean's families. They arrived in person with a member from victim services, expressed their condolences, and gave the general details of where each girl was found. The victim services representative, who was the same for both cases, provided counseling and resources to each family, a resource that was especially crucial for Kayla McKay's younger siblings at the time as the community reported many attempted teen suicides around the area.

Justin Brooks' parents did not receive a fateful knock on the door from police as they had heard that a body had been discovered at the waterfront and decided to go down there to see if it was their eldest son. Just as they arrived, they received a phone call from an investigator asking where they were so that they could give the official death notification. Justin's mother was able to talk with the investigator at the waterfront. He showed them where the scene was and briefly discussed the events of the night before. Unfortunately, this is where the communication between investigators and Justin's family stopped.

As mentioned previously, investigators determined Justin Brooks' case to be a suicide very shortly after discovering the body.[17] A few days later this determination would change to accidental slip-and-fall and then again to drowning some months after, but the initial determination had an impact on the family's access to victim services. Christine Martin inquired with the coroner to find out if the family had been provided any support structure during the investigation: "I asked her about victim services. 'Did they come over?... What part did they play in it?' And she said they didn't contact them at all." As the days went by after Justin's death, his mother noted that no one had attempted to contact her with information: "I had no phone call from anybody… I was just left … sitting there dealing with it myself." She ended up contacting investigators herself at this point, determined to get answers even if she had to launch her own investigation, despite the fact that standard investigative guidelines exist so that she should not have to do so.

[17] Investigators are permitted to make baseline assumptions about manner of death at the scene, to support the inclusion of additional investigative measures, but they cannot make a final determination without the coroner's analysis of the body.

All three families expressed dissatisfaction with the lack of information available to them about the investigations. Justin Brooks' mother even went as far as to submit multiple FOI requests to learn about case procedures and investigator conclusions (the police FOI returned no investigative information and the coroner FOI provided a largely redacted report). There are many standard practice procedures and victims' rights protections that state the families should have had more information made available to them than investigators provided. The *Canadian Victims Bill of Rights* (2015) mandates that the families should have been able to request general case information, at any point in the investigation, including on the procedures conducted, what support services were available to them, and how to file a misconduct complaint if they chose to do so. International policy further states that the 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" (UNHROHC, 2017, p. 4). Also, BC *Provincial Policing Standards* acknowledge the importance of the family's role in an investigation and require that they "must be kept appropriately informed of the progress of an investigation, and treated with compassion and respect" (2020, p. 127).

None of the three case investigations demonstrated adequate conduct in these regards. Kayla McKay's family waited two years after the case was officially closed without their knowledge, to speak with investigators and finally see images of their granddaughter's body.

> It was about two years after the whole thing [that] everything happened and then they finally came around and … asked us if we wanted to see the pictures of Kayla … He came and told us that they had closed the case a while ago and now they wanted … to show us [that it] was really Kayla… He asked us if we had any questions. We asked, 'why weren't we

> informed that they had closed the case a while ago before he came?' (Kayla McKay's grandmother, 2014)

This is a direct violation of international investigative standard practices which provides that the family is entitled to information and regular progress reports during all phases of the case (UNHROHC, 2017).

Emmalee McLean's aunt also had trouble getting a straight answer out of investigators about what had happened to her niece and who the primary suspect was. The RCMP contacted her to explain that there was nothing more they could do for the case unless someone came forward with more evidence but at the same time would not confirm whether they had questioned the key suspect that had left Prince Rupert the day after Emmalee died. Community rumors and advice from hospital staff to look into the mysterious bruises on her niece's body were the only sources of information that Emmalee's aunt could get. As mentioned earlier, the coroner's report arrived a year and a half after the investigation and was vague in the details of the bruises but detailed on the blood alcohol level.

Justin Brooks' mother received the coroner's report in the mail and nothing more. When she first spoke with the investigators at the scene, she noticed that there was no exchange of contact information or offer for the family to ask questions at a later time. "The police weren't the ones necessarily making contact with her. She would email them or get her husband to phone them and [was] trying to find out any sort of information" (C. Martin, 2014). A primary question, in the beginning, was that the family wanted to know if it was indeed Justin's body that was pulled from the water as, like the other families, they were not permitted to see the body until the funeral service.

During the first interactions with the family after the death notification, standard investigative practice provides that the family should select a designated individual to identify the body at the morgue (Geberth, 2015). In Justin Brooks' case, none of the family members were permitted to see him until the funeral service.

> I was practically begging [the coroner] to go see him. I said 'I could just go up there and look and then leave, no problem.'… I wanted to know if it was my son or not. 'Cause I said, 'we're going through these steps. Everyone's telling me he needs clothes and we need a casket and we need to do this and we need to do that and we need to do programs,' and I said … 'why are you guys doing this? Because we don't even know if it's him.' (Justin Brooks' mother, 2014)

Kayla McKay's grandfather held the same disbelief about whether the police had the right person in the morgue but was also kept from viewing her: "When they did find her, I want[ed] to go and identify the body - they said there was no need for it." The last time Kayla's grandparents saw her was on the Tuesday afternoon when she left home to attend the party; there was a closed casket because of the length in time between Kayla's death and the funeral service. Her grandfather reflected on the difficulty of not seeing her after she died and the effects it had on their family:

> 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 handled it. (Kayla McKay's grandfather, 2014)

Additional concern comes in the consideration that both Kayla McKay and Emmalee McLean's families had discrepancies in who was notified to identify the body. Kayla was cared for by her grandparents and Emmalee by her aunt, yet investigators contacted both girls' biological parents for identification. The investigators adequately

conducted standard procedure by contacting the next of kin (or legal guardians) for identification, but in this instance the standard itself is inadequate. The hierarchy of next of kin based on legal guardianship, especially in Indigenous cases, disregards how families that do not follow a conventional nuclear family model may not receive the same support as standard biological parent-child families. The UNHROHC (2017) acknowledges this discrepancy in standard practice and requires investigative agencies "to respect the culture and customs of all persons affected by the investigation, as well as the wishes of family members, while still fulfilling their duty to conduct an effective investigation" (p.11). This requires further discussion based on standard investigative practice rhetoric and colonial assumptions about family structure.

5.1.8. Cold Cases

Standard Investigative Practices	Conduct in Kayla McKay's case	Conduct in Emmalee McLean's case	Conduct in Justin Brooks' case
Cold cases			
Case referred to cold case unit if unsolved for a prolonged period without progress	N/A	N/A	Inadequate: Case remains open after eight years with no official cold case designation
Cold case investigators maintain five cases maximum at a time	N/A	N/A	-
Establish routine protocol for investigation and repeat review of new forensic techniques and personnel progress	N/A	N/A	-

Table 5.8 Adequate and Inadequate Cold Case Procedures Conducted for Justin Brooks' Case

The line that separates adequate and inadequate conduct for cold case determination is subjective. Standard investigative practices set clear guidelines for how a

case should be continuously reviewed once determined cold, but the problem lies in the missing set definition for what qualifies as a cold case and what does not. For Kayla McKay and Emmalee McLean's cases, despite the wishes of the families, both were officially closed, meaning unless new evidence comes to light, they do not qualify for cold case status. Justin Brooks' case, however, is still open after eight years with little investigative breakthrough. Upon reflection of the inquiry launched by VATJSS, UBCIC, and BCCLA, one of the family advocates commented that Justin Brooks' case would seemingly close and open on a whim when they attempted to file the FOI for information on the investigation.

> They kept opening and closing the case. They've opened and closed that case so many times it was always based on convenience ... 'Oh no that case is closed.' 'Oh, OK. So, then we can access the FOI if it's closed?' And then, 'oh no. No, no, it's open.' … I would imagine that that case is still deemed open because they don't want to pass any of the information around at all, but the families should have access to that information … so my question is with the RCMP, how many of those cases are deemed open only because they want to protect the information? Not because they're hoping for somebody to solve it. (C. Martin, 2021)

The concern here is two-fold: first, if Justin Brooks' case remains open then the family has a significantly harder time accessing case information via an FOI request because of the claim that it could jeopardize the investigation. Second, if the case remains open, for whatever reason, but does not get designated as cold nor assigned to a cold case unit, then the likelihood for new evidence or breakthrough becomes significantly limited. The benefit of a cold case unit, as indicated in the standard investigative procedure summary, is that single investigators take control of the case, with both fresh eyes and a smaller caseload than regular detachment investigators (Barcus et al., 2019).

At the time of Justin Brooks' candlelight vigil in 2013, the BCCLA organized a meeting with the local RCMP to inquire about their impressions of the investigation conduct so far. The general response from the police was one of satisfaction that provided a 'case that hasn't been solved is never closed' mentality. This did not satisfy how the investigators defined what qualifies as a closed or open case and what standard they had, if any, to inform how a case is closed. The former policy director of the BCCLA at the time, Micheal Vonn, who was asked to investigate the nature of the conduct provided in the three cases in 2014, noted that this was a very diplomatic response that would have been right for an official investigator to give. She also noted that without a set definition, that all institutional roles agreed upon, it is difficult to argue for adequacy or inadequacy on this issue.

5.1.9. Checks and Balances

Standard Investigative Practices	**Conduct in Kayla McKay's case**	**Conduct in Emmalee McLean's case**	**Conduct in Justin Brooks' case**
Checks and balances			
Investigators required to follow all procedural conduct outlined in policing standards	Inadequate: Not all standard procedures were performed	Inadequate: Not all standard procedures were performed	Inadequate: Not all standard procedures were performed
Small agencies must establish standard procedures for investigators and make them publicly accessible	Inadequate: Family and advocate did not have access to standard procedures	Inadequate: Family and advocate did not have access to standard procedures	Inadequate: Family and advocate did not have access to standard procedures

Standard Investigative Practices	Conduct in Kayla McKay's case	Conduct in Emmalee McLean's case	Conduct in Justin Brooks' case
Checks and balances			
Directors should review investigator conduct and compliance routinely and act on any reports of inadequacy	Inadequate: No formal review of investigator misconduct after challenge by VATJSS, UBCIC, and BCCLA	Inadequate: No formal review of investigator misconduct after challenge by VATJSS, UBCIC, and BCCLA	Adequate: Prince George RCMP follow-up on family complaint against Prince Rupert RCMP Inadequate: No formal review of investigator misconduct after challenge by VATJSS, UBCIC, and BCCLA
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	Inadequate: No inquest for child death	Inadequate: No inquest for child death	Adequate: Coroner ordered autopsy to reassess determination (slip and fall to drowning)
Civilians may file official complaints for review	-	-	Adequate: Family submitted official complaint which led to additional investigators from PG Inadequate: No formal results from complaint against Prince Rupert RCMP – no change in investigation misconduct

Standard Investigative Practices	Conduct in Kayla McKay's case	Conduct in Emmalee McLean's case	Conduct in Justin Brooks' case
Checks and balances			
Investigators are transparent; investigative procedures and outcome provided to public and families	Inadequate: Investigation information not accessible to public or families	Inadequate: Investigation information not accessible to public or families	Inadequate: Investigation information not accessible to public or families

Table 5.9 Adequate and Inadequate Check and Balance Procedures Conducted for all Three Cases

Check and balance procedures exist for all investigators, law enforcement and medico-legal, to address the concerns posed by the families in these three cases. The standard investigative practice summary pulls examples from multiple sources, including federal and provincial laws, such as the BC *Provincial Policing Standards* (2020), the *Police Act* (1996), the *RCMP Act* (1985), and the *Coroners Act* (2007). All of which require some variation of the phrase "it is the responsibility of every member: …to perform the member's duties promptly, impartially and diligently, in accordance with the law and without abusing the member's authority" (RCMP Act, 2013, c. 18, s. 27). The outcomes of these measures in each case vary between adequate and inadequate conduct, particularly when considering whether investigators performed their duties accordingly and if their respective organizations kept them accountable when they failed to do so.

Justin Brooks' mother filed an official complaint against the Prince Rupert RCMP for their investigative conduct which effectively brought in an investigator from the Prince George detachment to review the investigation. This is an adequate response required by the *RCMP Act* (1985) in 45.53 (1):

> Any individual may make a complaint concerning the conduct, in the performance of any duty or function under this Act or the Witness Protection Program Act, of any person who, at the time that the conduct is

> alleged to have occurred, was a member or other person appointed or employed under Part I.

The addition of the Prince George investigator was enough to satisfy that Justin Brooks' mother's complaint was acknowledged and received official action. However, the effort put forth by this additional investigator seemed to fall short like that of the original investigators as communication with the family soon ceased to exist. "He pretty much took my statement and everything … and he said, he'll get in contact with us, but that was last year, and I haven't heard from [him] since… So, I have no clue what they're doing" (Justin Brooks' mother). There were no records of further institutional accountability reviews to address misconduct in any of the three cases.

In Kayla McKay and Emmalee McLean's cases, there was an insufficient effort by the coroner to make recommendations for youth cases, especially with the presence of high blood alcohol levels. The check and balance standards in these cases rely largely on the accountability of investigator reporting, requiring those in a position of power to acknowledge that these steps may not have been conducted to standard or at all. The VATJSS advocate for the three families commented that check and balance efforts in Prince Rupert are unlikely to happen without active pressure from public roles unaffiliated with investigative institutions: "they have no interest in making sure that this comes to light because if it did, they'd be in a lot of trouble" (C. Martin, 2021). Unfortunately, public response against investigator misconduct is restricted by the further inadequate efforts to provide the accessible information about the investigative procedures and outcomes to the public and families (UNHROHC, 2017).

5.2. Supplemental Investigative Procedures

Each case investigation involved conduct from non-investigators in addition to the procedures performed by the RCMP and the coroner. This section acknowledges the efforts conducted by the families, advocacy organizations, and, in Justin Brooks' case, a private investigator. These efforts fall both within the standard practice procedures required for traditional investigators, such as canvassing, evidence collection, and scene investigation, as well as procedures outside of that set summary, such as fundraising and public inquiry.

5.2.1. Family Action

Each of the families acted in their own right to investigate their loved ones' deaths. Kayla McKay, Emmalee McLean, and Justin Brooks' families conducted additional canvassing and interviews to supplement the inadequate procedures by investigators. Though, as noted by Micheal Vonn after her review of the three cases, family action, in this sense, may also have been a natural product of small community connection. For instance, Kayla McKay's grandparents took to Facebook to ask their granddaughter's friends if they knew anything about the night of the party – an unconventional resource that would be unavailable to investigators. Both Emmalee McLean's aunt and Justin Brooks' mother knew the people who were with their kids the night of their deaths and questioned them when they saw them in the community: "I did see their mom 'cause I knew who they were. And she said that they had nothing to do with it and that they were home" (Emmalee McLean's aunt). "Yeah, [he was] like six

something tall, but I ran into him, I got in his face, [and] I said 'I know you guys were all down there and I know it was you'" (Justin Brooks' mother).

Each family indicated that the RCMP was neither diligent nor thorough in their interviews of the people who could have witnessed each death, so they, by logic and duty to their loved one, asked around the community themselves to get the information that could crack each case. This could be both an effective tool, as the literature indicates that the strained relationship between law enforcement and the Indigenous community may make police interviews less effective, but this also could be a danger to the families who interact with, and accuse, potential suspects (Chrismas, 2012; Comack, 2012). After spending time in Prince Rupert while reviewing the three investigations, Micheal Vonn noted that even if the RCMP had completed everything by the book, it is certain that the families would still conduct their own investigations. In a small-town community, where everyone knows everyone, they have the capabilities to ask around for information and the community itself is active in investigating rumors.

The family investigation *Justice for Justin* extended past just community interviewing as Justin Brooks' parents searched for new information on their own. After six months into the official investigation by the RCMP, Justin's family hired a PI to look into the case. This investigator worked diligently by interviewing multiple people, including the 7-11 employees to uncover the security footage that the RCMP had waited to collect up till that point, and kept a detailed record of those efforts for the family to review.

> Justin Brooks' mother: All the information we got was from the investigators (PIs), not the RCMP.

> Christine Martin: [The PIs] were pretty good at providing [information]… they would come in after they were finished, sit with her, and share all the information that they found to date.

When the Prince Rupert RCMP would not arrange for the polygraph equipment to come from Prince George, Justin's mother fundraised around $16,000 to get the PI to do it instead. Justin's father, who had been a first responder at one point, also investigated the scene at the waterfront and was the first to notice that the tide would have been low in the early morning when the coroner estimated that Justin had died of drowning. When the investigators continued to disregard Justin's family, and his mother knew of other families in the area who had the same experience (like Kayla McKay and Emmalee McLean's families), she reached out to the executive director at VATJSS, Christine Martin at the time, to discuss solutions:

> [Justin Brooks' mother] is the one that got in touch with me … They know that we kind of do justice … when she initially got into contact with me, what I did suggest is that she get in contact with [redacted] as well and then [redacted] got her to do a police complaint report. (C. Martin, 2014).

5.2.2. Advocacy Organizations

When Justin Brooks' mother was asked by interviewers who she thought the first people were who actually listened and were concerned for her she responded,

> Civil Liberties (BCCLA), because with everyone else here, they didn't give a crap and it just made me feel worse because I felt like they weren't doing enough and they weren't gonna' because they already told us that [it was] foul play or suicide and I told the guy 'he wouldn't commit suicide. He was scared of water.' And he did nothing.

Similar exasperation and disappointment came from Kayla McKay and Emmalee McLean's families when discussing the dismissal of the official investigators. All three cases identified that the presence of the advocacy organizations that started the inquiry

into each investigation brought a sort of hope that their child's case would not go unattended.

> I've known of others and the families haven't sort of come forward- with a bit of fear I might say with the RCMP. So yeah, that they (Kayla McKay, Emmalee McLean and Justin Brooks' families) … are the ones that mainly came forward and it is quite common, but a lot of our people don't know how, or how to access the information, or even someone to help them advocate because usually everybody's too afraid that they're going to get targeted themselves. So, because we're an organization, and … we were a high profile organization, then it really allowed us to do our job. (C. Martin, 2021)

VATJSS, UBCIC, and BCCLA were not the only organizations to advocate on behalf of the families. Kayla McKay's grandparents recalled how members of the Highway of Tears community organization came to their door with intentions of including Kayla in their list of missing and murdered Indigenous women and girls. The group posted Kayla's picture in the public's view including on television, online (in the news and on the group's Facebook page), and on the Highway of Tears awareness van.

Justin Brooks' mother also had media attention in that she discussed the case on multiple television and radio news channels, as well as newspapers, to set the facts about the investigation straight. After investigators reported varying outcomes for Justin's death – suicide, slip-and-fall, drowning, open, closed, open again – his mother made sure that the media presented the reality of the case correctly and further served as a voice for the community. Christine Martin mentioned that many other families in the community reported similar problems of inadequate investigations but would only approach the review team in private because of the fear of repercussion for speaking against the police. She also commented that the community had a norm where there would be media, investigator, and public attention, in some form, during the two-month window after a

tragedy, but, after that point, everyone would seemingly move on. This created an especial need for those in a position of power to keep the investigative ball rolling.

> The police made some comment about flying in these high-profile people in from Vancouver to talk … and I said good on us to do that, because our people (the Indigenous community) do not have people to come help them out and if you're evening the playing field, so be it. (C. Martin, 2021)

5.3. Summary Review of Case Conduct

When the amount of "adequate" and "inadequate" procedures is summed up for each of the three investigations, the resulting grades are disheartening. Table 11 conveys the breakdown of (in)adequate procedures for each case; showing that none of the cases displayed adequate conduct over 50% of the time.[18] This is of obvious concern when standard investigative practice expectation is that each case should have reported an adequacy grade of 100%.

The results indicate that, amongst the adequate conduct, investigators did well in their efforts to secure each crime scene which primarily consisted of requesting the presence of the coroner. Often in each case, adequate practices were considered as simply performing or initiating the required task, like police arriving at the death scene, evidence collected at the scene, or coroners summarizing their findings in the final report. The adequacy, however, developed into inadequacy in many places when accounting for the follow-through or quality of the procedures performed. For instance, while the police adequately arrived at the scene of Justin Brooks' death, they also took an hour to arrive

[18] Each investigation "grade" was calculated by (1) summing the "adequate" and "inadequate" procedures in each case and (2) averaging the adequacy count by the combined total. In procedures that had both an "adequate" and "inadequate" outcome, each were counted as a single score. Instance of "N/A" or blank procedures were not included in each calculation.

and had not provided the reportee enough information to prevent others from contaminating possible evidence. Evidence collection was adequate in each case in that it was retrieved in the first place, but inadequacy came when no plan was developed to return belongings to the families nor was there a plan for forensic analysis of such items. The coroner did well in many regards to complete and submit the final reports of each case to the families, but often did not provide a complete explanation of the findings nor availability to discuss such findings with the families.

	Kayla McKay	**Emmalee McLean**	**Justin Brooks**
Adequate	12	11	19
Inadequate	12	15	20
Grade (Adequate/Total x 100)	50%	42%	49%

Table 5.10 Investigative Conduct Adequacy Grade for Each Case

It provides little comfort in knowing that there were instances of adequate conduct or helpful investigators in each case when compared to the large proportion of inadequate conduct; particularly as these investigations are supposed to uncover why a family will never see their loved ones again. Standard investigation guidelines, whether required by law or informed by best practices, intend for all procedures to be adequately conducted. Additional worry comes with not knowing the adequacy of the procedures for which investigators will not provide information. Are there more instances in which they performed the appropriate practices? Or are the families' concerns of investigative inadequacy even more warranted that they are as the results stand?

As mentioned previously in the research, Kayla McKay, Emmalee McLean, and Justin Brooks' families knew the outcome of the study before it was conducted. The results presented in this chapter demonstrate that all three cases were inadequately investigated. The RCMP and medico-legal professionals are certainly allowed credit where credit is due for the quality work they did perform, but these instances cannot outshine the sheer number of standard procedures they conducted inadequately, nor for their limited accountability efforts. The analysis makes one thing perfectly clear: that all three families were failed by the investigators and the justice system.

In the next chapter, the research findings will be discussed as they draw connections to what we know about inadequate Indigenous death investigations from the literature. It will also provide a number of central themes presented by the participants in this study as to why these three investigations were inadequate and how professional roles can address the issue. It is evident there is a problem here; the next step is to make recommendations for future examinations and solutions.

Chapter 6. Discussion and Conclusion

There were overarching trends that came from the comparative design between standard investigative practices and case study conduct. Many demonstrated consistency with themes presented in the existing literature, implying a continuation of problems thought to be previously reconciled. These include repeated discussion on the state of Indigenous and police relationships in Prince Rupert and how they affect investigations, overarching concerns of the accessibility and assumptive rhetoric of standard investigative practices in general, and recommendations for preventing future inadequate investigations in Indigenous communities. This chapter will provide a detailed discussion of these points using references from the data and existing literature. It will also conclude the research with a final summary of trends, limitations, unanswered questions, and future directions.

6.1. Trouble in Prince Rupert

The results discussed in chapter five presented a central theme on the Indigenous community/law enforcement relationship and why inadequate conduct continued to occur. The consensus among families, advocates, legal reviewers, academics, and even a Grand Chief, is that Indigenous people are losing trust in investigators to investigate their deaths adequately. Critical Race Theory rears its ugly head as it contextualizes how this distrusting relationship likely came from the unequal power that white investigators had over the families (Hylton, 2012; Tyson, 2003). Investigators can dictate how a case is conducted, how much effort is put into it, and how much information they choose to provide to the community. Indigenous families have little ability to contest this conduct as society does not grant them equal power to do so and further stigmatizes them as

expectant victims (Ben-Porat, 2008; Gilchrist, 2010). This power struggle was most evident in four primary concerns noted in the data: that police inattention fosters mistrust, Indigenous stereotypes become justifications for case dismissal, similar inadequate investigations continue to go unaddressed, and the RCMP's structure prevents relationship repair with the local community.

6.1.1. Trust in Police

Micheal Vonn noted that, at the beginning of each death investigation, she never got the sense that families started with a sense of distrust that the police would do what was necessary. In some instances, officers made a lasting positive impression in their supportive and thorough conduct with the families. Kayla McKay's grandparents recalled a male officer from the RCMP who started on the case and did everything from taking them down to the scene to answer questions, to sending them a card giving his condolences. "They were really trying to help us when it happened but then all of a sudden, he got transferred out." The problem, as Kayla's grandmother revealed, was that the supportive officer was transferred out of Prince Rupert mid-way through the investigation and replaced with an inattentive investigator who inspired the growing distrust thereafter. This is consistent with the testimonies presented by many MMIWG families during public inquiry as they expressed initial confidence in investigator conduct but quickly lost it after repeat negligence and inattention (NIMMIWG, 2019).

Tensions formed between the more vocal family members and the investigators as cases started missing crucial procedures and communication ceased. Justin Brooks' mother reflected in her interview, "I don't think they (the RCMP) like me now after all

the pushing and the fighting with them." The families learned not to trust investigators to conduct adequate investigations after repeated instances of dismissal, silence, and disregard for their concerns. What is typically referred to as a right to discretion by investigators is more often interpreted as a controlling power over case information by everyone else. On multiple accounts, participants indicated that "this happens all the time" and that there is a lack of accountability to rectify it in the community. Investigator silence and inattention was a primary theme in MMIWG testimonies and a primary point of contention in many public inquiries and government reports (NIMMIWG, 2019; Oppal, 2015; RCMP, 2015; VPD, n.d.). This begs the question, why do these three cases report this inadequacy theme after recommendations exist to prevent it?

> There is a problem in BC when First Nations families and communities are unable to place their faith in law enforcement either to protect them or to properly investigate crimes committed against them. Across the north, we have heard from many First Nations communities that police treat them poorly compared to non-First Nations communities. The tragedy of missing and murdered women on the Highway of Tears is the most well-known example, but the problem extends well beyond that. (M. Vonn, 2020)

6.1.2. Racial Stereotyping

Manner and cause of death determinations made by investigators also came under fire after the consistent use of determinations of suicide or accidental drowning, with the presence of alcohol, for Indigenous cases in Prince Rupert. The BCCLA (2013) released a statement on this matter in their case review:

> The RCMP provided the families with discrepancies and have been vague on details regarding the deaths, quickly dismissing them by blaming the victims for their suspicious deaths by suggesting suicide, alcohol and accidental.

Indigenous community members have become used to these investigator determinations, knowing that these suggestions align easily with Indigenous stereotypes. Group Position Theory (GPT) would explain this as a possible tactic for police to use victim blaming terms to diminish decedent victimhood (Denis, 2020). As indicated in the results, once a satisficing determination of death that aligned with Indigenous stereotypes had been made, it appeared easier for investigators to disregard the families or the deceased as true innocents. From what other Indigenous cases tell us, these investigator perceptions tend to influence how media portray victims and how quickly police respond to missing person reports and conduct standard procedures (Epstein, 2021; Gilchrist, 2010).

The inadequacy evident in each investigation presents itself as police indifference, whether they intend it or not, which families then interpret as indifference toward Indigenous victims when accompanied with the same determinations given to other members of their community.

> Palys: Is part of it that 'it's just another Aboriginal body in the water?'
> Justin Brooks' mother: Yeah.
> Christine Martin: Just another Indian-.
> Justin Brooks' mother: Slip-and-fall, suicide, that's the easy answer for them.
> Christine Martin: Acute alcohol overdose I think is another one that they use.

Micheal Vonn noted that, across all cases, there was an emphasis placed on alcohol, which is something that Indigenous cases are consistently accompanied. This also applies to the consistent relationship between drowning and Indigenous stereotyping about the inability to swim where we see a large proportion of Indigenous "accidental drowning" or water deaths. We can draw parallels along these lines between, for example, Justin

Brooks' case and Jordan Wabasse's case from Thunder Bay, where both young Indigenous investigations quickly turned inadequate after investigators claimed the determination as accidental (CRCC, 2021). The emphasis of alcohol intoxication, in all cases, also aligned with common concerns made by MMIWG testimonies and media reports where substance use took center stage in how cases were interpreted and presented (Gilchrist, 2010, Khajeh, 2020; Lheidli T'enneh First Nation et. al., 2006; Morton, 2016; NIMMWG,2019; Slakoff & Fradella, 2019).

These determinations have two different implications that require attention in the professional realm: first, if Indigenous deaths are indeed products of accidental drowning and alcohol intoxication, then investigators need to explain their findings to families so that it is clear that the final determination came from investigative rigor instead of dismissive assumptions. Second, if these determinations are products of racial stereotyping as existing testimonies and literature imply, then they impact both the families and the validity of how professionals understand Indigenous mortality. Their repeated conclusion of inaccurate determinations would suggest that accidental drowning and alcohol intoxication are a norm for Indigenous deaths in the province and would skew the focus of preventative measures. Either way, the reality in which the local community believes that police rely on stereotypes during investigations is a pertinent concern that requires further attention and action.

6.1.3. Repeat Incidents

Rumor travels fast in a small community like Prince Rupert, especially when many Indigenous families have experienced the same incidents of threats of violence and

inadequate follow-up by police to investigate those events. One case, recalled by Kayla McKay's grandmother, occurred not too far from where the family lived, suggesting that this sort of thing could happen to anyone in the community:

> We tell people about what happened [to Kayla] and then after the service [at the church] … some people come to us and say 'oh, we went through the same thing.' Like this [other Indigenous girl] up in Burns Lake where the cops wouldn't do anything. They don't care because she's First Nations. They just buried her under a pile of snow, just left her there. They threatened the family that if they tried to do anything then they would be the next ones to be gone, that's how bad it is up in that area. We are pretty lucky… that you guys are helping us. (Kayla McKay's grandmother, 2014)

Justin Brooks' mother brought up another case that was well known in the community as it had occurred in the same area in which Justin was found:

> Justin Brooks' mother: And there's those two brothers that were found around the waterfront too, that drowned, and they (the RCMP) said 'oh, they were drunk. They slipped and fell in,' but they were both floating in the water down there not far from where my son was.
>
> Christine Martin: And they were both bruised from head to toe and their explanation for that was that they got into a fight with each other and then fell in the water.

The community has a wealth of other cases that they know of where Indigenous people die under suspicious circumstances and the police respond in an unprofessional manner. Where commonalities exist in the accessible literature is in the disbelief that investigators provide when Indigenous families express concerns. In both scenarios, investigators had the power to disbelieve and discredit what Indigenous families present as facts. This was also the case in Kayla McKay and Alloura Wells', from Justice Epstein's review, cases when police did not believe that they were truly missing at the time when the families made their initial reports (Epstein, 2021).

Indigenous families have developed distrust that police will investigate their deaths should they end up in the same situations, but they also learn from these instances that the police may not protect them either. In Justin Brooks' case, witnesses, who the RCMP will not identify, report that two men in a white truck approached Justin at the waterfront after his altercation with his friends. It was these individuals who the witnesses say beat Justin and threw him in the water. The seriousness of this statement is that the mysterious white truck is well known to many Indigenous people in the area. Emmalee McLean's aunt spoke about the white truck as well in her interview. She mentioned that when her son was walking home near the waterfront one morning, not long after Emmalee McLean's death, two men from a white truck pulled up beside him, picked him up, and threw him in the water. "Every time he seen the white truck, he just kept an eye out." The RCMP are aware of these incidents, and the white truck, but families say they have not acted on the reports,

> [The RCMP] just pretend like they [don't know]. I asked him … 'is this not concerning to you that like a number of people … are talking about this white truck?' … I think one person worked in an office somewhere said he was going to the local 7-11 or somewhere and people just jumped out and started chasing him with a bat and he just started running. (C. Martin, 2014)

The relationship between these repeat incidents and police disbelief suggests an interesting notion on investigator/community expectations. If investigators expect the Indigenous community to believe them when they make determinations, then they should reciprocate by believing the community when they present problems.

6.1.4. Small-town Policing

Repairing the relationship between the local RCMP and the Indigenous community is difficult in a small town. Investigative inattentiveness in a place like Prince Rupert may also have some tethering to concerns of high police turnover and officer dissatisfaction with rural setting placements (Jones, Ruddell, & Summerfield, 2019). Newer police officers are often provided first placements in areas that are perceived as undesirable - often rural, small-town areas that happen to have a large Indigenous population - which manifests a disconnected mentality to the local community as they hope to transfer to a more favorable detachment (Jones, Ruddell, & Summerfield, 2019; Ross, 2009). Micheal Vonn noted that because Prince Rupert has a higher turnover of rookie officers, they are not as likely to form connections with the locals because of their lack of investment in the area. Further, she noted that these green officers may not have the rural training to adequately accommodate the cases in that setting. Context counts: for officers who come from urban experience and training, there may not be the same expectation for community building or additional training requirement for the change in terrain. Then, as these new officers learn how to work in these small communities over time, they are transferred again back to the urban world.

This is not to say that all officers are inattentive to their duties when placed in an area such as Prince Rupert. As revealed by Kayla McKay's grandparents, her investigation began with dedicated officers who performed adequately in many regards, but they were transferred out to another detachment before the case closed. Even with the presence of investigators who have attachments to the local community, if they are removed mid-way through an investigation, the replacement officer is unlikely to have

the same context or emotional commitment, to finish the case as the first (Michalko, 2016). For the Indigenous community, this may mean that families choose to turn to other agencies with whom they already have positive relationships, instead of relying on the RCMP for help at all.

6.2. Overarching Concerns with Standard Conduct

The focus of this research is on assessing case investigations, but investigator conduct is only half the battle when the standards that inform their practices may also be part of the problem. Settler Colonial Theory provides a pointed explanation for why certain investigative procedures were inadequate in each case: the standard investigative practices maintain colonial expectations that do not support Indigenous victims (Denis, 2020). Shifting the focus away from the investigator to the standards that govern them, the results indicated a strong imbalance with many standard expectations and the realistic ability for them to help Indigenous cases. This included the accessibility of those standards for families to argue against misconduct and the colonial assumptions embedded in many procedural texts.

6.2.1. Investigative Standards Availability and Rhetoric

When asked how the BCCLA assessed the adequacy of each case investigation in 2014, Micheal Vonn said they started with the same mindset of the present research: finding standard practice guidelines for police and medico-legal professionals and comparing them to each investigation. They found that these standard resources did not exist at the time, “if there are any, they must be so rare.” The ability to effectively argue if an investigation was adequately conducted or not is impaired by the lack of standard

regulations with which to compare them. Investigators can argue that releasing such standards to the public may hinder future investigations, but preventing legal representatives' access to such resources limits their ability to uphold accountability when conduct is not up to par. The one-sided nature of this information also allows investigators to defend themselves when accused of inadequacy as anyone arguing against them would not have the access to the information that would prove otherwise.

Given that standard investigative procedures are not publicly accessible, this left the BCCLA at a loss of how to review the investigative conduct in each case and effectively argue on behalf of the families with little information. With the lack of investigative case files and standards in which to contest conduct, they had to rely on subjective interpretations of their arguments and ask, for each investigative step, “is this reasonable? Is this reasonable to ignore? Is this reasonable to follow up?” However, as Micheal Vonn stated, their expertise as legal researchers did not prepare them to answer these questions. This suggests that if there is any hope in arguing for inadequate investigative conduct, without the standards that govern investigators, it would behoove the process to use best practice logic from professionals in the criminological and forensic fields and informing all involved parties, including the families, about what these practices entail.

6.2.2. Impacts of Colonial Assumptions

Investigative standards themselves, either official or informed by best practice, may also contribute to inadequate conduct for Indigenous cases specifically. Although many investigative procedures have proven effective in solving death cases for decades,

the colonial assumptions that inform how they are conducted and regulated may cause further harm to Indigenous families. For instance, in a popular academic textbook used to train investigators, best practice for death notification states "that detectives have a uniform officer accompany them when making an official death notification. The presence of an officer in uniform can have a calming effect..." (Geberth, 2015, p. 375). The standard here has good intentions but misses the mark in acknowledging that Indigenous people, or any other marginalized community, may not find comfort in the presence of a uniformed officer. The discussion in this research thus far has clearly demonstrated this discomfort on multiple accounts. For Indigenous cases, standard practice would do well to include suggestions for the presence of an Indigenous community advocate or support representative instead of another officer. This is best exemplified in Kayla McKay and Emmalee McLean's cases when the attending victim services representative provided opportunities for support and counseling to the families after the notification.

Standard expectations for autopsy are also provided as matter of fact without acknowledgment of Indigenous cultural beliefs regarding handling the dead (Smiles, 2018). In his investigative guidebook, Geberth sets out that investigators should "inform the survivors that a medico-legal autopsy is required to establish the exact cause of death" (2015, p. 376). Further, the BC *Coroners Act* (2007) allows a coroner to order a post-mortem examination from a medical professional including dissection, blood/urine/stomach/intestine analysis, or other affiliated necessary assessments without approval from the family first. There is well-meaning investigative intent in these standard procedures in that an autopsy, and subsequent invasive testing on the deceased,

provide cases with necessary evidence that could lead to a suspect or conviction. The problem is that they do not acknowledge, nor set appropriate alternative procedures, for Indigenous families who may believe that the deceased should not be handled in such a manner. This is the case in a variety of death-related procedures as, ultimately by law, family desires are always overridden by investigation requirements.

In the present case studies, the colonial assumption on family dynamics had a similar effect; even though investigators adequately contacted people to identify Kayla McKay and Emmalee McLean's bodies, they were not the family members who regularly cared for the girls. The RCMP investigators followed the procedures provided in the standard investigative practice summary by finding the next of kin for identification, in these two cases the biological parents, but failed to acknowledge that Kayla McKay's grandparents and Emmalee McLean's aunt raised them like their own children - a not uncommon family structure for Indigenous people/s (Fuller-Thompson, 2005). The concern here is that while the investigative step had been achieved, the families suffered lasting trauma after questioning if the bodies belonged to their girls or not. Measures to decolonize investigative procedures would be worthwhile not only to improve Indigenous wellbeing during cases but also would equip investigators with the necessary tools to avoid claims of inadequacy by families.[19]

[19] Academics should also take note of the sparse research available on appropriate Indigenous death protocols.

6.3. Limitations

To improve research dependability, this section discusses the methodological and data limitations provided in both study designs, as well as the delimitations of the research in general.

6.3.1. Standard Investigative Practice Summary

The standard investigative practice summary created is in no way exhaustive. As mentioned, preference went to BC or Canadian standards in establishing primary procedure, but due to the insufficient nature of those location-specific documents, much of the summary was generalized in a wider context using resources established in the United States. Many of these U.S. resources do suggest that their investigative standards are intended for international application; regardless, a limiting acknowledgment is due for the judicial dissimilarities between the U.S. and Canada and any impacts that this may have on death investigations and procedure.

Methodological limitations also exist in this context. Resource inclusion was according to prestige and support by experienced authors or reviewers, but this does not suggest that all relevant resources are included in the sample. In reference to textbook resources, many educational texts for investigative procedure exist, but inclusion relied on readily available texts that were regularly recommended by reviewers, had experienced authors in a variety of related fields, and had overlapping consensus on specific procedures to improve internal validity (Thomas & Magilvy, 2011).

Alternative methods for compiling resources and constructing the standard practice summary could best involve a detailed content analysis of all such investigative procedural resources (reports, educational texts, or otherwise). This method would create the opportunity for a greater dive into investigative literature and compile a larger sample in which to create trends from professional consensus. This method was performed at a basic level, however, as multiple researchers, including myself and two other helpful work-study assistants, conducted literature reviews of standard procedural texts for roughly seven months. The sample selected allowed for the inclusion of all uncovered provincial policies and provided a balance of recommendation reports and academic texts to create a generally complete, and uncluttered, procedural summary.

6.3.2. Multi-case Study Comparison

The internal validity, or credibility, of a qualitative research study, comes with its own set of limitations given the interpretative data provided by participants (Krefting, 1991; Thomas & Magilvy, 2011). I used a triangulation of different data resources to address concerns of one-sided interpretation by any one participant. Official documents of investigative procedures cross-examined interview testimonies for accuracy of events and provided a review of investigative events by each family, the advocacy organization, legal reviewers, coroners, and a PI. The use of multiple sources established a greater level of construct validity by creating a chain of evidence (Yin, 2014; Zach, 2006).

An additional limitation comes from interpreting the reasons behinds investigator inadequacy in each case. It is unknown from the data collected if investigation misconduct was a product of uneducated investigators in a rural community, or if it was

due to prejudice against Indigenous victims. This limitation is best addressed in future research by comparing white death investigation practices for similar age, sex, and location variables.

6.3.3. Delimitations

The time and space of a two-year master's program during COVID-19 restricted parts of the research.[20] Additional data could benefit the thoroughness of each case analysis including interviews with RCMP officers, coroners, and other community members in Prince Rupert. Expansion of the data in this manner became limited by the time required to establish such relationships with related individuals and travel restrictions set by the pandemic. The data included in the final analysis were accessible within the required research timeframe and digital communication but also was sufficient in understanding the nature of each case investigation.

Methodologically, the employed study design provided the best, and most rational, outcome for the cases provided. This does not mean, however, that there are not alternative methods that may be better equipped to assess the primary topic. For a truly comparative case study design, this study would benefit from including a non-Indigenous case sample with which to form a comparison, first the standard procedures and each case themselves, and second, the two relationships of Indigenous and non-Indigenous investigation (in)adequacies. This study, however, places greater emphasis on understanding what happened in each case, and the nature of their investigations

[20] The COVID-19 pandemic required global isolation measures, restricting travel and in-person human interaction, to prevent further spread of the virus. Meetings with the research team, and the secondary interviews, thus had to be conducted virtually over phone or on video message software.

individually, as an intrinsic case study (Stake, 2003). My ability to use my findings to provide insight into the wider issue of inadequate Indigenous death investigation came also from using an instrumental case study design by connecting my findings to the existing literature.

6.4. Recommendations

After reviewing the events of each death investigation, participants gave recommendations for procedures that may best improve and prevent future Indigenous concerns of inadequate investigator conduct. The consensus was an increase in research on the reality of the situation in Canada and establishing a focused watchdog organization for families to call upon in these circumstances.

6.4.1. Investigative Research

There is a significant lack of data on Indigenous death investigations and mortality. As summarized in chapter two, there are a multitude of public inquiries and institutional reports on MMIWG cases in Canada, but much of the research in those realms rely on public testimonies and limited government statistics (Epstein, 2021; NIMMIWG, 2019; Oppal, 2015; RCMP, 2015). Christine Martin expressed hope for a better source of data about investigations themselves for Indigenous cases and for researchers to expand their focus past the terms and methods used in the past.[21]

[21] Race-based statistics are notably controversial, as many argue that they may justify discriminatory policies, but recent years have seen minority groups now advocating for their collection as now there is little data available to investigate the unequal treatments towards them (Owusu-Bempah & Millar, 2010). One solution posed by these groups is for a dedicated group or organization to collect and research race-based data for the purpose of measuring these inequities alone.

> I was even looking into [how] every year the BC Coroner's office releases reports … but they don't really identify … Aboriginal [status]. They just identified drowning, right? From this year, this year, and this year, and then they do it in regions and not necessarily like Prince Rupert and that sort of thing. So, you have to almost be able to decipher that. (C. Martin, 2014)

It is difficult for advocacy and watchdog organizations to investigate Indigenous issues without proper data. West, Reder, and Bell (2020) note that in small communities it is often the local Indigenous people who know the true outcomes of an investigation, be it murder, suicide, or accident, but authorities do not accept individual testimonies as evidence without the proper data to back it up. The problem is that the data do not exist to support these claims. The local Indigenous community of Prince Rupert widely accept that there is a disproportionate number of Indigenous deaths near the waterfront that are labeled as 'accidental' or 'suicides' but there are no empirical data to verify this belief as the Coroners service does not record manner of death by race/ethnicity or city. This missing data would best inform the need to investigate the question of whether Indigenous mortality statistics accurately represent Indigenous deaths or if investigative inadequacy skews these results.

The other under-researched issue is the lack of access to investigative case files. Standard investigative practice requires consistent and thorough documentation of investigative procedures and outcomes which could answer a variety of questions still left unanswered about (in)adequate conduct. "What [would] be great [is] to measure, with each of these cases and the cases across BC … when did they determine the cause of death or how many hours before [did] they determine that" (C. Martin, 2021)? As in Justin Brooks' case, the RCMP supposedly made claims to suicide before the coroner had conducted a preliminary examination of the body, also well before Justin Brooks' body

was sent to Vancouver for autopsy, destroying their chances of collecting what could have been useful evidence. These instances of early determination may imply investigator tunnel vision which restricts their willingness to explore all possible avenues because they already believe to know what happened. Official case documentation, if adequately recorded, could do well to answer how these events played out and if tunnel vision was apparent. These files could provide vital data to answering how Indigenous cases are investigated across the country, as personal testimonies are often dismissed as skewed information, suggesting that the only true way to argue whether Indigenous investigations are disproportionately inadequate is to launch a full-scale research analysis into the police files themselves. This is of course a difficult procedure to undergo for researchers outside of the RCMP, given the security requirements for investigative information, but suggestions of institutional racism indicate the need to conduct the research regardless. The RCMP would do well to foster a better working relationship with researchers into how they conduct their duties to address this. If it is not accessible for academics to conduct, then the government should take the responsibility of assessing the adequacy of Indigenous death investigation conduct, particularly as they make regular claims of reconciliation.

6.4.2. Watchdog Organization

Good data and extensive research find worth by informing practice, which every participant in the study called for. All advocated for the development of a watchdog organization that consisted of a multidisciplinary team that had information access and knowledge to lead families through inadequacy claims. This team of experts would address many of the concerns presented throughout the research. This includes having

legal and government professionals who have access to restricted files or who may know the routes to obtain vital case information, medical and forensic experts who can provide a second review of coroner reports and final determinations, and investigative and research personnel who have the necessary critical tools to challenge the adequacy of standard conduct in any investigation; “you know, to me, that's the answer - is having that body of experts” (C. Martin, 2021).

The presence of an organizational body like this addresses the additional concerns posed by the current advocacy groups that have been working with these three cases: “when we pose any kind of questions it's just this big wall of: ‘sorry, we can't respond. No comment. Still under investigation.’ That kind of response” (C. Martin, 2014). Currently, victim’s rights groups have limited authority to demand answers and action from investigators, especially those protected by the Canadian government, so any new organization must have federally acknowledged power to access the data necessary to challenge cases. Research into Indigenous death investigations would best support the need for an organization of this type for families to call upon, but the greatest challenge will come with obtaining the right amount of power to demand change while also existing outside of the institutions that need to be challenged. Whatever the recommendation to tackle inadequate Indigenous death investigations, Micheal Vonn put it best: what we should collectively ask is, what brings peace? Whatever is done, it should create appropriate change to create peace for the families.

6.5. Conclusion

How adequately were the three Indigenous death investigations in Prince Rupert conducted when compared with standard investigative procedures? The results of this study answer: inadequately. Law enforcement and the Coroners Service performed a few standard procedures adequately but by and large, missed the mark in conducting the basic steps outlined in the standard investigative practice summary. In inquiries before this research, investigators were accused of this same outcome and responded with the same claims of budget deficiencies and understaffing, but this fails to account for many of the standard procedures that do not require funding nor many personnel (i.e., supporting families, interviewing locals, waiting for coroner determinations before closing a case).

The results indicate the need to assess other Indigenous investigations as the existing literature, and the research participants, suggest that there are thousands of other families that share the same stories. There are trends across the three case investigations in that each of the three young Indigenous deaths had insufficient canvassing, improper management and use of evidence, limited access to coroner explanation of body examinations, and severely lacking support services for the surviving families. It is concerning for any investigative step to be inadequate in any single case, Indigenous or otherwise, but for results to indicate that many procedural discrepancies were shared across three demographically similar cases is a larger problem that requires wider attention and action.

The family testimonies of investigative conduct in these three cases have support by advocacy and legal organizations like VATJSS, UBCIC, and BCCLA all of which

express the need for greater action to both address the still unanswered questions of the three case studies themselves and to prevent similar cases from arising. Seventeen years have passed since Kayla McKay's death and her grandparents still want to know why no charge or inquiry addressed the death of a 13-year-old girl. Eleven years have passed since Emmalee McLean's death and her aunt still wants to know what happened the night before she died. Six years have passed since Justin Brooks' death and his parents still want to know why no assault charges went to the people who beat their son and what investigators have been doing in the past years since the case is still open. These questions could be best answered by open and honest communication with investigators who hold the revealing case files, but, unfortunately, this is unlikely to happen. It will take a watchdog organization with appropriate authority to demand answers for these families. It will also take a reassessment of standard investigative practices to prevent future inadequate cases as the discussion indicates an inherent flaw in procedures supporting Indigenous cases.

The problem of inadequate Indigenous death investigation is an epidemic that extends past Prince Rupert, British Columbia, and Canada. Professionals have their work cut out for them with the power of voice they have; this includes government officials, law enforcement, medico-legal practitioners, human rights advocates, the public, and academics. Indigenous communities have fought against these issues, and numerous others intertwined with them, on their own because few adequately listen, but they should not have to alone. As an academic, there are obvious next steps that require research support for effective change. One of which includes expanding the Indigenous death investigation assessment to broader contexts, as families across North America want

answers for their loved ones' deaths as well. The other is to explore and change the colonized data that informs how we investigate and assess Indigenous death investigation cases.

> *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.* (Kayla McKay's grandfather)

References

Association of Chief Police Officers Centrex. (2006). *Murder Investigation Manual* (3rd ed.). Wyboston, UK: National Centre for Policing Excellence.

Akee, R., & Feir, D. (2018). First people lost: Determining the state of status First Nations mortality in Canada using administrative data. *Canadian Journal of Economics, 52*(2), 1-45.

Aluwihare-Samaranayake, D. (2012). Ethics in qualitative research: A view of the participants' and researchers' world from a critical standpoint. *International Journal of Qualitative Methods, 11*(2), 64-81.

Amnesty International. (2009). *No more stolen sisters: The need for a comprehensive response to discrimination and violence against Indigenous women in Canada*. Retrieved April 13th, 2021 from: https://www.amnesty.ca/sites/default/files/amr200122009en.pdf

Anaya, S. J. (2015). Report of the special rapporteur on the rights of indigenous peoples in the situation of indigenous peoples in Canada. *Arizona Journal of International & Comparative Law, 32*, 143.

Anderson, W. J. (2012). 'Indian drum in the house' A critical discourse analysis of an apology for Canadian residential schools and the public's response. *International Communication Gazette, 74*(6), 571-585.

Arriagada, P. (2016). First nations, Métis and Inuit women. *Statistics Canada, Social and Aboriginal Statistics Division*. Retrieved April 13th, 2021 from https://www150.statcan.gc.ca/n1/pub/89-503-x/2015001/article/14313-eng.pdf

Barcus, H., Heurich, C., Ritter, N., Schwarting, D. E., & Walton, R. (2019). *National Best Practices for Implementing and Sustaining a Cold Case Investigation Unit*. Retrieved April 13th, 2021 from https://www.ojp.gov/pdffiles1/nij/252016.pdf

Barker, B., Goodman, A., & DeBeck, K. (2017). Reclaiming Indigenous identities: Culture as strength against suicide among Indigenous youth in Canada. *Canadian Journal of Public Health, 108*(2), e208-e210.

BC Civil Liberties Association, BC Indian Chiefs meeting with the Brooks family. (2013). Retrieved April 13th, 2021 from https://bccla.org/2013/05/media-thenorthernview-bccla-bcindianchiefs-meet-brooksfamily/

BC Coroners Service, & First Nations Health Authority. (2017). *A review of First Nation youth and young adult injury deaths: 2010 - 2015*. Retrieved April 13th, 2021 from https://www.fnha.ca/Documents/FNHA-BCCS-A-Review-of-First-Nations-Youth-and-Young-Adults-Injury-Deaths-2010-2015.pdf

Beniuk, J. (2012). Indigenous women as the other: An analysis of the missing women's commission of inquiry. *The Arbutus Review, 3*(2), 80-97.

Ben-Porat, G. (2008). Policing multicultural states: Lessons from the Canadian model. *Policing & Society, 18*(4), 411-425.

Bogdan, R., & Biklen, S. K. (1997). *Qualitative research for education*. Boston, MA: Allyn & Bacon. 276.

Boyce, J. (2015). Police-reported crime statistics in Canada, 2014. *Juristat, Vol. 36, no. 1*, Statistics Canada Catalogue no. 85-002-X

British Columbia. (2020). Provincial Policing Standards. Retrieved December 13th, 2020 from https://www2.gov.bc.ca/gov/content/justice/criminal-justice/policing-in-bc/policing-standards

British Columbia Civil Liberties Association. (2013, May 3). BC Indian Chiefs meeting with the Brooks family. *The Northern View*. Retrieved April 13th, 2021 from https://www.thenorthernview.com/news/bc-civil-liberties-association-bc-indian-chiefs-meeting-with-the-brooks-family/

Brooks, A., & Hesse-Biber, S. N. (2007). An invitation to feminist research. In S. N. Hesse-Biber & P. L. Leavy (Eds.), *Feminist research practice* (pp. 1-24). Thousand Oaks, CA: Sage Publications.

Brown, D. (2018, March 20). Alloura Wells remembered by friends, family, LGBT mourners as a 'great soul'. *CBC*. Retrieved April 13th, 2021 from https://www.cbc.ca/news/canada/toronto/alloura-wells-remembered-by-friends-family-lgbt-mourners-as-a-great-soul-1.4584999

Bucholtz, A., Scott, S., & Purdy, R. (2015). *Death Investigation*. Waltham, MA: Anderson Publishing. 386.

Bucik, A. (2016). *Canada: Discrimination and violence against lesbian, bisexual, and transgender women and gender diverse and Two Spirit people on the basis of sexual orientation, gender identity and gender expression*. Retrieved April 13th, 2021 from https://egale.ca/wp-content/uploads/2016/10/UN-CEDAW-Treaty-Body-Paper-2016-09-30.pdf

Campbell, A. (1996). *Bernardo investigation review: Report of Mr. Justice Archie Campbell.* Toronto: Queen's Printer for Ontario. 34.

Canadian Victims Bill of Rights, Statutes of Canada (2015, c. 13, s.2). Retrieved May 10th, 2021 from the Justice Laws website: https://laws-lois.justice.gc.ca/eng/acts/c-23.7/page-1.html

Cao, L. (2014). Aboriginal People and Confidence in the Police. *Canadian Journal of Criminology and Criminal Justice, 56*(5), 499-526. doi:10.3138/cjccj.2013.E05

Carrier Sekani Family Services. (n.d.). *Highway of Tears: Preventing violence against women*. Retrieved December 13th, 2020 from https://www.highwayoftears.org/.

Chrismas, R. (2012). The people are the police: Building trust with Aboriginal communities in contemporary Canadian society. *Canadian Public Administration, 55*(3), 451-470.

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*. Retrieved April 13th, 2021 from https://www.crcc-ccetp.gc.ca/pdf/boushie-rep-en.pdf

Comack, E. (2012). *Racialized policing: Aboriginal people's encounters with the police*. Halifax & Winnipeg: Fernwood Pub. 254.

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

Coroners Act, Statutes of British Columbia (2007, c.15). Retrieved September 14th, 2020 from the BC Law website:https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/07015_01

Crenshaw, K. (2018). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics [1989]. In K. T. Bartlett & R. Kennedy (Eds.), *Feminist legal theory* (pp. 57-80). New York: Routledge.

Delgado, R., & Stefancic, J. (2021). *Critical race theory: An introduction* (Vol. 20). New York: New York University Press. 225.

Denis, J. S. (2020). *Canada at a Crossroads: Boundaries, Bridges, and Laissez-Faire Racism in Indigenous-Settler Relations.* Toronto: University of Toronto Press. 365.

Dorrell, M. (2009). From reconciliation to reconciling: Reading what" we now recognize" in the government of Canada's 2008 residential schools apology. *ESC: English Studies in Canada, 35*(1), 27-45.

Dunbar, C. (2008). Critical race theory and Indigenous methodologies. *Handbook of critical and indigenous methodologies*, 85-99.

Epstein, G. (2021). *Missing and missed: Report of the independent civilian review into missing person investigations*. Retrieved May 1st, 2021 from

Erskine, K. L., & Armstrong, E. J. (2021). *Water-related death investigation: practical methods and forensic applications*. Boca Raton, FL: CRC Press. 438.

Esser, F., & Vliegenthart, R. (2017). Comparative Research Methods. *The International Encyclopedia of Communication Research Methods*, 1-22. doi:10.1002/9781118901731.iecrm0035

Faulkner, S. L., & Trotter, S. P. (2017). Data Saturation. *The international encyclopedia of communication research methods.* 1-2.

Firestone, W. A. (1993). Alternative arguments for generalizing from data as applied to qualitative research. *Educational researcher, 22*(4), 16-23.

Fisher, B. A. J., & Fisher, D. R. (2012). *Techniques of Crime Scene Investigation* (8th ed.). Boca Raton, FL: CRC Press. 529.

Fisher, C. B., & Anushko, A. E. (2008). Research ethics in social science. *The SAGE handbook of social research methods*, 95-109.

Fleming, J., & Zegwaard, K. E. (2018). Methodologies, Methods and Ethical Considerations for Conducting Research in Work-Integrated Learning. *International Journal of Work-Integrated Learning, 19*(3), 205-213.

Fuller-Thomson, E. (2005). Canadian First Nations grandparents raising grandchildren: A portrait in resilience. *The International Journal of Aging and Human Development, 60*(4), 331-342.

Furniss, E. (1999). *The burden of history: Colonialism and the frontier myth in a rural Canadian community*. Vancouver, BC: UBC Press. 237.

García-Del Moral, P. (2014). Representation as a Technology of Violence: On the Representation of the Murders and Disappearances of Aboriginal Women in Canada and Women in Ciudad Juarez. *Canadian Journal of Latin American and Caribbean Studies, 36*(72), 33-62. doi:10.1080/08263663.2011.10817014

Geberth, V. J. (2014). *Practical homicide investigation checklist and field guide* (2nd ed.). Boca Raton, FL: CRC Press. 158.

Geberth, V. J. (2015). *Practical homicide investigation: tactics, procedures, and forensic techniques* (5th ed.). Boca Raton, FL: CRC Press. 1296.

Gibbins, R., & Ponting, R. (1986). Historical Background and Overview. In R. Ponting (Ed.), *Arduous Journey*. Toronto: McLelland and Stewart.

Gilchrist, K. (2010). "Newsworthy" victims? Exploring differences in Canadian local press coverage of missing/murdered Aboriginal and White women. *Feminist media studies, 10*(4), 373-390.

Giles, A. R., Brooks Cleator, L., McGuire-Adams, T., & Darroch, F. (2014). Drowning in the Social Determinants of Health: Understanding Policy's Role in High Rates of Drowning in Aboriginal Communities in Canada. *aboriginal policy studies, 3*(1-2). doi:10.5663/aps.v3i1-2.21706

Gillham, B. (2000). *Case study research methods*. London: Bloomsbury Publishing. 106.

Glaser, B. G. (2002). Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods, 1*(2), 23-38.

Hainsworth, J. (2019). B.C. coroners service fears its manual could show people how to get away with murder. *Vancouver Courier*. Retrieved December 13th, 2020 from https://www.vancourier.com/b-c-coroners-service-fears-its-manual-could-show-people-how-to-get-away-with-murder-1.23615093

Hamilton, A. C., & Sinclair, C. (1991). Report of the Aboriginal Justice Inquiry of Manitoba. Volume 1: The Justice System and Aboriginal People. *Manitoba, Canada: Queen's Printer*.

Hansen, J. G., & Dim, E. E. (2019). Canada's Missing and Murdered Indigenous People and the Imperative for a More Inclusive Perspective. *International Indigenous Policy Journal, 10*(1). doi:10.18584/iipj.2019.10.1.2

Hargreaves, A. (2017). *Violence against Indigenous women: Literature, activism, resistance*. Waterloo, Ontario: Wilfrid Laurier University Press. 281.

Hunt, S. (2016). *An introduction to the health of two-spirit people: Historical, contemporary and emergent issues*. Prince George, BC: National Collaborating Centre for Aboriginal Health Prince George, BC. 32.

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

Inter-American Commission on Human Rights. (2014). *Missing and Murdered Indigenous Women in British Columbia, Canada*. Retrieved December 13th, 2020 from https://www.oas.org/en/iachr/reports/pdfs/indigenous-women-bc-canada-en.pdf

Jones, N. A., Ruddell, R., & Summerfield, T. (2019). Community policing: Perceptions of officers policing indigenous communities. *Canadian Journal of Criminology and Criminal Justice, 61*(1), 41-65.

Keller, J. (2012, February 15). Pickton was one of hundred of suspects, Mountie says. *The Globe and Mail*. Retrieved December 13th, 2020 from https://www.theglobeandmail.com/news/british-columbia/pickton-was-one-of-hundreds-of-suspects-mountie-says/article546356/

Kelsall, D., & Bowes, M. J. (2016). No standards: medicolegal investigation of deaths. *Canadian Medical Association Journal, 188*(3), 169. doi:10.1503/cmaj.160041

Khajeh, M. (2020). Missing and Murdered Indigenous Women and Girls: The Role of Political Campaigns/Administrations in Undermining Violence Against Indigenous Women and Girls in Canada. *POLITICUS*, 26.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *American journal of occupational therapy, 45*(3), 214-222.

Lheidli T'enneh First Nation, Carrier Sekani Family Services, Carrier Sekani Tribal Council, Prince George Nechako Aboriginal Employment Training Association, & Prince George Native Friendship Center. (2006). *A collective voice for those who have been silenced - Highway of Tears Symposium report*. Retrieved April 1st, 2020 from https://www.highwayoftears.org/uploads/Highway%20of%20Tears%20Symposium%20Recommendations%20Report%20-%20January%202013.pdf

Lifesaving Society Canada. (2019). *Canadian Drowning Report*. Retrieved April 13th, 2021 from http://www.lifesavingsociety.com/media/314749/cdndrowningreport2019.pdf

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage. 416.

Longstaffe, M. (2017). Indigenous women as newspaper representations: Violence and action in 1960s Vancouver. *Canadian historical review, 98*(2), 230-260.

Macoun, A., & Strakosch, E. (2013). The ethical demands of settler colonial theory. *Settler Colonial Studies, 3*(3-4), 426-443.

Maloney, M. S. (2018). *Death scene investigation: procedural guide* (2nd ed.). Boca Raton, FL: CRC Press. 570.

Maloney, R. (2015, September 14). Harper reportedly denies saying MMIW inquiry wasn't high on 'radar'. *The Huffington Post*. Retrieved April 13th, 2021 from http://www.huffingtonpost.ca/2015/09/14/harper-missing-murdered-indigenous-women_n_8136604.html

McCalla, A., & Satzewich, V. (2002). Settler Capitalism and the Construction of Immigrants and" Indians" as Racialized Others. In W. Chan & K. Mirchandani (Eds.), *Crimes of Colour: Racialization and the Criminal Justice System in Canada*. Peterborough: Broadview Press.

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*. Toronto: Doubleday Canada. 332.

McKenzie, J. S. (2017). Emotional reflexivity and the guiding principle of objectivity in an inter-disciplinary, multi-method, longitudinal research project. *Sociological Research Online, 22*(1), 68-80.

McLeod, J. (2000). *Beginning Postcolonialism*. New York: Manchester University Press. 333.

Merriam, S. B., & Tisdell, E. J. (2015). *Qualitative research: A guide to design and implementation*. Newark: John Wiley & Sons. 347.

Michalko, R. (2016). *Obstruction of Justice: The Search for Truth on Canada's Highway of Tears.* Markham, Ontario: Red Deer Press. 271.

Miladinovic, Z., & Mulligan, L. (2014). Homicide in Canada, 2014. *Statistics Canada*. Retrieved December 13th, 2020 from https://www150.statcan.gc.ca/n1/pub/85-002- x/2015001/article/14244-eng.htm

Miles, M. B., Huberman, A. M., & Saldaña, J. (2018). *Qualitative data analysis: A methods sourcebook*. Thousand Oaks, CA: Sage publications. 381.

Misco, T. (2007). The frustrations of reader generalizability and grounded theory: Alternative considerations for transferability. *Journal of Research Practice, 3*(1), M10-M10.

Moeke-Pickering, T., Cote-Meek, S., & Pegoraro, A. (2018). Understanding the ways missing and murdered Indigenous women are framed and handled by social media users. *Media International Australia, 169*(1), 54-64.

Monchalin, L. (2016). *The colonial problem: An Indigenous perspective on crime and injustice in Canada*. Toronto: University of Toronto Press. 412.

Morton, K. A. (2016). Hitchhiking and missing and murdered indigenous women: A critical discourse analysis of billboards on the highway of tears. *Canadian journal of sociology, 41*(3), 299-326.

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*. Retrieved March 21st, 2020 from https://www.mmiwg-ffada.ca/transcripts-exhibits/

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*. Retrieved March 21st, 2020 from https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Executive_Summary.pdf

National Inquiry into Missing and Murdered Indigenous Women and Girls. (n.d.). *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls.* Retrieved March 21st, 2020 from https://www.mmiwg-ffada.ca/final-report/

National Institute of Justice US, & United States National Medicolegal Review Panel. (1999). *Death investigation: A guide for the scene investigator*. District of Columbia: U.S. Dept. of Justice, Office of Justice Programs, National Institute of Justice. 80.

National Institute of Justice US, & United States National Medicolegal Review Panel. (2011). *Death investigation: A guide for the scene investigator (technical update)*. District of Columbia: U.S. Dept. of Justice, Office of Justice Programs, National Institute of Justice. 48.

Native Women' s Association of Canada. (2010). *What their stories tell us: Research findings from the sister's in spirit initiative*. Ottawa, ON: Native Women's Association of Canada. 58.

Native Women's Association of Canada. (2019). Fact sheet: Missing and murdered aboriginal women and girls. Retrieved December 13th, 2020 from https://www.nwac.ca/resource/fact-sheet-missing-and-murdered-aboriginal-women-and-girls/

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*. Retrieved January 2nd, 2021 from https://www.nwac.ca/wp-content/uploads/2020/06/REPORT-CARD.pdf

Nest, M. W., Reder, D., & Bell, E. (2020). *Cold Case North: The Search for James Brady and Absolom Halkett*. Regina: University of Regina Press. 311.

Nielsen, M., & Robyn, L. M. (2019). *Colonialism is crime*. New Brunswick, NJ: Rutgers University Press. 262.

Oppal, W. (2015). *Forsaken: The report of The Missing Women Commission of Inquiry-executive summary*. Retrieved December 13th, 2020 from https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/about-bc-justice-system/inquiries/forsaken-es.pdf

Owusu-Bempah, A., & Millar, P. (2010). Research note: Revisiting the collection of justice statistics by race in Canada. *Canadian Journal of Law and Society, 25*, 97.

Palmater, P. (2016). Shining Light on the Dark Places: Addressing Police Racism and Sexualized Violence against Indigenous Women and Girls in the National Inquiry. *Canadian Journal of Women and the Law, 28*(2), 253-284. doi:10.3138/cjwl.28.2.253

Perrault, S. (2015). Criminal victimization in Canada, 2014. *Juristat.* Retrieved April 13th, 2021 from https://www150.statcan.gc.ca/n1/pub/85-002-x/2015001/article/14241-eng.pdf

Police Act, Revised Statutes of British Columbia (1996, c 367). Retrieved September 14th, 2020 from the BC Laws website: https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96367_01

Polit, D. F., & Beck, C. T. (2010). Generalization in quantitative and qualitative research: myths and strategies. *International Journal of Nursing Studies, 47*(11), 1451-1458. doi:10.1016/j.ijnurstu.2010.06.004

Punch, K. F. (2013*). Introduction to social research: Quantitative and qualitative approaches*. Thousand Oaks, CA: Sage. 320.

R. v. Stinchcombe, Supreme Court of Canada. (1991). Retrieved May 10th, 2021 from the Supreme Court Judgements website: https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/808/index.do

Razack, S. (2015). *Dying from improvement: Inquests and inquiries into Indigenous deaths in custody*: Toronto: University of Toronto Press. 309.

Razack, S. H. (2018). When place becomes race. *Race and racialization: Essential readings*, 113-129.

RCMP Act, Revised Statutes of Canada (1985, c.R-10). Retrieved September 14th, 2020 from the Justice Laws website: https://laws-lois.justice.gc.ca/eng/acts/r-10/

Reifenberg, K. (2018). The Starlight Tours. *On Politics, 11*(2), 13-30.

Robinson, D., & Martin, K. (2016). *Arts of engagement: Taking aesthetic action in and beyond the Truth and Reconciliation Commission of Canada*. Waterloo, ON: Wilfrid Laurier University Press. 385.

Rodgers, G. (2019, August 24). A serial killer loose on the Highway of Tears? *Dying Words*. Retrieved December 13th, 2020 from http://dyingwords.net/is-a-serial-killer-loose-on-the-highway-of-tears/

Ross, C. (2009). Policing in isolated communities: It's what you make of it. *Royal Canadian Mounted Police Gazette, 71*, 10-11.

Royal Canadian Mounted Police. (2015). *Missing and Murdered Aboriginal Women: A national operational overview*. Retrieved December 13th, 2020 from

https://www.rcmpgrc.gc.ca/wam/media/460/original/0cbd8968a049aa0b44d343e76b4a9478.pdf

Royal Canadian Mounted Police. (2016). Project E-PANA. Retrieved September 10th, 2019 from http://ridgemeadows.cb-bc.rcmp-grc.gc.ca/ViewPage.action?contentId=27048&languageId=1&siteNodeId=23

Royal Commission on Aboriginal Peoples. (1996). *Report of the Royal Commission on Aboriginal Peoples*. Retrieved December 13th, 2020 from https://www.bac-lac.gc.ca/eng/discover/aboriginal-heritage/royal-commission-aboriginal-peoples/Pages/final-report.aspx

Saldaňa, J. (2009). *An Introduction to codes and coding*. In J. Saldaňa (Ed.), The coding manual for qualitative researchers (pp. 1-31). Los Angeles, CA: SAGE.

Sanjari, M., Bahramnezhad, F., Fomani, F. K., Shoghi, M., & Cheraghi, M. A. (2014). Ethical challenges of researchers in qualitative studies: The necessity to develop a specific guideline. *Journal of medical ethics and history of medicine, 7*.

Schmalleger, F., & Volk, R. (2013). *Canadian criminology today: Theories and applications*. Toronto: Pearson Canada. 388.

Scientific Working Group for Medicolegal Death Investigation. (2012). *Principles for Communicating with Next of Kin during Medicolegal Death Investigations*. Retrieved April 27th, 2021 from: https://swgmdi.org/images/nokguidelinesforcommunicationwithnok6.14.12%202.pdf

Slakoff, D. C., & Fradella, H. F. (2019). Media Messages Surrounding Missing Women and Girls: The Missing White Woman Syndrome and Other Factors That

Influence Newsworthiness. *Criminology, Criminal Justice, Law, & society, 20*, 80.

Smiles, D. (2018). "… to the Grave"—Autopsy, settler structures, and indigenous counter-conduct. *Geoforum, 91*, 141-150.

Smith, L. T. (2013). *Decolonizing methodologies: Research and indigenous peoples*. London: Zed Books Ltd. 436.

Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage. 173.

Stake, R. E. (2003). Case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 134-164). Thousand Oaks, CA: Sage.

Stefanovich, O. (2020, June 3). Indigenous women's organization gives Ottawa failing grade on its MMIWG response. *CBC*. Retrieved April 13th, 2021 from https://www.cbc.ca/news/politics/stefanovich-nwac-mmiwg-inquiry-one-year-anniversary-1.5596172

Stillman, S. (2007). 'The missing white girl syndrome': disappeared women and media activism. *Gender & development, 15*(3), 491-502.

Strega, S., Janzen, C., Morgan, J., Brown, L., Thomas, R., & Carriere, J. (2014). Never innocent victims: Street sex workers in Canadian print media. *Violence against women, 20*(1), 6-25.

Talaga, T. (2017). *Seven fallen feathers: Racism, death, and hard truths in a northern city*. Toronto: House of Anansi. 363.

Taylor, C. (2009). Health and safety issues for Aboriginal transgender/two spirit people in Manitoba. *Canadian Journal of Aboriginal Community-Based HIV/AIDS Research, 2*(1), 5-26.

Thomas, E., & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for specialists in pediatric nursing*. 16(2), 151–155. https://doi.org/10.1111/j.1744-6155.2011.00283.x

Truth and Reconciliation Commission of Canada. (2015a). *Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. Retrieved September 10th , 2019 from http://nctr.ca/assets/reports/Final%20Reports/Executive_Summary_English_Web.pdf

Truth and Reconciliation Commission of Canada. (2015b). *Truth and Reconciliation Commission of Canada: Calls to Action*. Retrieved September 10th, 2019 from http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

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

United Nations Human Rights Office of the High Commissioner. (2017). *The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016)*. Retrieved April 13th, 2021 from New York and Geneva:

Vancouver Police Department. (n.d.). *Vancouver Police Department Actions Taken Resulting from the*

Missing Women Investigation Review. Retrieved December 13th, 2020 from https://vpd.ca/police/assets/pdf/lessons-learned-mw-investigation.pdf

VanEvery, L. (2019). *The Examination of News Media Representation of Indigenous Murder Victims in Canada: A Case Study of Colten Boushie's Death.* Wilfrid Laurier University, Waterloo, ON. 102.

Watkins, K., Anderson, G. S., Bulmer, W., & Rondinelli, V. (2019). *Evidence and Investigation: From the Crime Scene to the Courtroom* (2nd ed.). Toronto: Emond Publishing. 443.

Yin, R. K. (2014). *Case study research: Design and methods* (5th ed.). Thousand Oaks, California: Sage Publications. 282.

Zach, L. (2006). Using a multiple-case studies design to investigate the information-seeking behavior of arts administrators. *Library trends, 55*(1), 4-21.