

**ONTARIO PROVINCIAL POLICE DISCIPLINE HEARING
IN THE MATTER OF ONTARIO REGULATION 268/10**

**MADE UNDER THE *POLICE SERVICES ACT*, RSO 1990,
AND AMENDMENTS THERETO;**

**AND IN THE MATTER OF
THE ONTARIO PROVINCIAL POLICE**

AND

STAFF SERGEANT B.W. (Bradley) SAKALO #9305

CHARGE: NEGLIGENCE OF DUTY

DECISION WITH REASONS

Before: Superintendent Lisa Taylor
Ontario Provincial Police

Counsel for the Prosecution: Mr. Adrien lafrate
Ministry of the Solicitor General

Counsel for the Defence: Mr. James Girvin
Ontario Provincial Police Association

Public Complainant: Ms. Denise Lucier

Hearing Date: June 26, 27, 28, July 30, 31, 2019

This decision is parsed into the following parts:

PART I: OVERVIEW;

PART II: THE HEARING;

PART III: SUBMISSIONS,

PART IV: ANALYSIS AND FINDINGS; and,

PART V: DECISION.

PART I: OVERVIEW

Parties to this Hearing include:

- Staff Sergeant (S/Sgt) Brad Sakalo, represented by Mr. James Girvin;
- Mr. Iafrate represented the Ontario Provincial Police (OPP);
- The Public Complainant, Ms. Denise Lucier.
 - Ms. Lucier did not have legal representation however indicated she understood she had the right to do so. The hearing process and her role in it, was explained to her and she was provided with a copy of the tribunal rules. She actively participated throughout the hearing process.

Background

S/Sgt Sakalo faces a *Police Services Act (PSA)* misconduct charge in relation to an April 2017 traffic investigation. He was the S/Sgt in charge of the Traffic Management Unit (TMU). Provincial Constable (P/C) Tamminga, a member of the TMU, investigated a motor vehicle collision wherein the Public Complainant's husband died as a result of injuries sustained in the collision and the Public Complainant herself sustained serious life altering injuries. The misconduct allegation stems from S/Sgt Sakalo's supervisory actions in response to the investigation.

A hearing was held in Windsor, Ontario commencing on June 26, 2019 and concluded on July 31, 2019.

Allegations of Misconduct

S/Sgt Sakalo stands charged with neglect of duty in that he did without lawful excuse, neglected or omitted promptly and diligently to perform a duty as a member of the Ontario Provincial Police, contrary to section 2(1)(c)(i) of the Code of Conduct contained in the Schedule to Ontario Regulation 268/10, as amended.

Particulars of Allegations:

On Sunday April 9, 2017 a motor vehicle collision occurred in Kingsville, Ontario and was investigated by P/C Rene Tamminga of the Essex OPP TMU. The driver of an

automobile failed to stop at a stop sign and struck a motorcycle. The driver of the automobile sustained minor injuries. The occupants of the motorcycle, a husband and wife, sustained serious injuries. The husband died two weeks following the collision as a result of his injuries. P/C Tamminga's supervisor was S/Sgt Bradley Sakalo.

On or about July 17, 2018, the wife, hereafter referred to as Denise Lucier, submitted a complaint to the Office of the Independent Police Review Director (OIPRD) alleging that police failed to conduct a thorough investigation into the incident and that they failed to communicate with her during the investigative process after her repeated calls to the investigating officer went unanswered.

S/Sgt Sakalo, being the Operations Manager for Essex OPP Detachment, is responsible for benchmark collisions within his detachment area. He is the immediate supervisor for P/C Tamminga. It is alleged that S/Sgt Sakalo was neglectful in performing his duty when:

- On or about January 19, 2018 S/Sgt Sakalo received a list of benchmark collisions. The list included P/C Tamminga's fatal motor vehicle collision investigation which showed a status that the investigation required updating. S/Sgt Sakalo, being the responsible Operations Manager for this incident, did not take appropriate supervisor action. He did not enquire about the investigative status to ensure that it was current. Had he done so he would have learned that there were issues with the investigation
- On or about January 23, 2018 Denise Lucier called the detachment expressing her frustration with the nine month old investigation and her intent to file a complaint. S/Sgt Sakalo returned her call and assured her that P/C Tamminga would call her back. S/Sgt Sakalo, being the supervisor for P/C Tamminga and the responsible member for oversight of benchmark collisions, should have been familiar with this investigation and known that there were investigative delays which could be critical in a court process.
- On or about February 4, 2018 P/C Tamminga charged the at-fault driver with Criminal Code offences of Dangerous Driving Causing Death and Dangerous Driving Causing Bodily Harm with a court date of March 22, 2018. The case did not come before the courts on March 22 as P/C Tamminga had not submitted a court brief and the courts were unaware of the charges. S/Sgt Sakalo, being his immediate supervisor and aware of the issues behind this investigation, failed to properly supervise P/C Tamminga to ensure this matter appeared before the court.
- The complainant left several phone messages on the detachment answering

machine between March 2018 to June 2018 and sounded increasingly frustrated with each call. The detachment Administrative Assistant sent P/C Tamminga an email with each call and also carbon copied S/Sgt. Sakalo. Knowing the increased frustration on the part of Denise Lucier, S/Sgt Sakalo did nothing to ensure her concerns were being addressed and that the investigation was progressing.

- On or about June 21, 2018 the Deputy Crown Attorney, being upset with the delay in the brief coming before the court, met with S/Sgt Sakalo and P/C Tamminga. They were advised that due to the delay there was no prospect of conviction.
- On or about June 28, 2018 S/Sgt Sakalo learned that Denise Lucier was going to hire a lawyer and notify the Windsor Star newspaper of her concerns with the police investigation. It was this information that prompted S/Sgt Sakalo to advise P/C Tamminga to contact Denise Lucier as soon as possible.

S/Sgt Sakalo was neglectful in his duties in that he failed to provide proper supervision for this incident.

Plea

At the outset of the hearing on June 26, 2019, S/Sgt Sakalo entered a plea of not guilty to neglect of duty.

Decision

There is clear and convincing evidence to support a finding of misconduct and I find S/Sgt Sakalo guilty of neglect of duty, contrary to section 2(1)(c)(i) of the Code of Conduct contained in the Schedule to Ontario Regulation 268/10, as amended.

My reasons for the decision are as follows:

PART II: THE HEARING

Exhibits

The exhibits tendered in this matter are listed in Appendix A.

Witnesses

The Prosecution witnesses included the following:

- Ms. Denise Lucier, Public Complainant
- P/C Rene Tamminga, Officer In Charge (OIC) of related incident
- Ms. Lise Pharand, Essex County Administrative Assistant
- A/S/Sgt Erica Vanroboys, Professional Standards Bureau (PSB) Investigator
- Sergeant (Sgt) Mike Gruszka (then A/S/Sgt), Essex Detachment, Acting Operations Manager
- A/Inspector Andrea Quenneville, West Region Traffic Operations
- Sgt Tracy Blanchard, Essex Detachment Platoon Supervisor
- Inspector Stuart Bertram (then S/Sgt), Essex Detachment, South Operations Manager *Throughout this decision he will be referred to as S/Sgt Bertram

Defence counsel witnesses included:

- S/Sgt Brad Sakalo, Respondent Officer

Witness Testimony

The following is not meant to be an exhaustive overview of witness testimony and counsel submissions. I will speak to what I consider to be the most relevant evidence, addressing the issues at hand. Relevant evidence will be discussed in further detail within the analysis section.

In order to evaluate and give weight to the evidence I have heard, it is necessary to assess the credibility of witnesses, where applicable. First, I will outline my understanding of a credibility assessment. For each witness, I need to consider whether their testimony is consistent with the preponderance of probabilities where an informed person would recognize my conclusions as reasonable. This is particularly important when the evidence provided, contradicts other evidence.

As the trier of fact, I must carefully consider each witness and their respective opportunities for knowledge and observation, their judgement, recollection and the ability to communicate what they have observed. Even a credible witness can be honestly mistaken and render testimony that may be less reliable.

Summaries of Testimony

Ms. Denise Lucier – Public Complainant

Evidence in Chief

Ms. Lucier testified that she has been an accountant for the past 25 years and lives in LaSalle, Ontario. On April 17, 2017 she was the passenger on a motorcycle with her partner, Mr. Paul Thompson, when they became involved in a motor vehicle collision. Due to the

extent of her injuries she has little memory of the incident but was later told what happened.

Ms. Lucier lost her leg at the scene of the accident and had numerous fractures including her femur, pelvis, diaphragm, neck, wrist, and she had sustained a mild brain injury. She was in the hospital for three weeks followed by three months in long term care. She has undergone numerous surgeries and still has daily occupational and physical therapy.

Her partner, Mr. Thompson was on life support as a result of significant injuries and sadly, he succumbed to his injuries on April 21, 2017.

Ms. Lucier testified that P/C Tamminga was the OIC of the OPP investigation and when she came out of the Intensive Care Unit, he attended to see her and ask her about what she recalled of the accident. She did not document any notes at the time but later created a log of emails and conversations beginning in August 2017 when she started communicating with P/C Tamminga. She clarified that the log was made in July 2018 from her phone records and a spiral pad that she jotted notes on. This log covering a time period from August 2017 to June 2018 was made an exhibit (14) and Ms. Lucier referenced it throughout her testimony.

I have included specific reference to Ms. Lucier's testimony in relation to the events outlined in the *Timeline* as well as in the analysis associated to those events. Overall, Ms. Lucier's testimony addressed her numerous attempts to communicate with P/C Tamminga in relation to the status of the charges against the other driver involved in the tragic accident.

Ms. Lucier spoke to no one other than P/C Tamminga in 2017 but in January 2018 she contacted the OPP detachment and requested a supervisor contact her. She testified that on January 23, 2018 she spoke to S/Sgt Sakalo who assured her that he would speak to P/C Tamminga and have him call her. She testified she did not discuss the type of charges but expressed frustrations as to why charges had not been laid.

Through early 2018 there were several communication events between P/C Tamminga and Ms. Lucier; all of these contacts were initiated by Ms. Lucier. On March 12, 2018, P/C Tamminga returned her call and agreed that she could attend the court date regarding the other driver. This conversation however was followed up with a call from P/C Tamminga on March 21, 2018, wherein he told her that the court date was not going to occur but he would keep her informed as to the next date.

With no further communication from P/C Tamminga through April and most of May 2018, Ms. Lucier sent P/C Tamminga an email on May 24, 2018 asking for an update. P/C Tamminga responded to this email on May 28, 2018 noting that the file was moving forward. On June 13, 2018 she sent another email to P/C Tamminga asking for an update but no

reply was received.

Ms. Lucier testified that following little action by P/C Tamminga, she did not believe him and so she made efforts herself to determine the status of the charges. On June 18, 2018, Ms. Lucier contacted the Victim Witness Assistance Program (VWAP) believing she had contacted the Crown Attorney's office. The VWAP representative indicated he could see nothing in the system related to her collision.

Ms. Lucier testified that she was frustrated; she contacted the OPP again that same day and spoke to administrative personnel whom she advised that she would be reaching out to her local Member of Provincial Parliament (MPP) and the Windsor Star if she did not receive an answer in two days. She testified her motivation for this was that she wanted someone to help her. By this time she was in touch with a criminal lawyer for advice.

Ms. Lucier testified that after the above noted call to the OPP, P/C Tamminga emailed her, responding to the email she sent on June 13, 2018. He advised her that he had a meeting with the Crown Attorney the following week to secure a date. On June 19, 2018, she then responded back via email requesting the name of the Crown Attorney, as she did not believe anything was happening with the file.

Ms. Lucier testified that on June 28, 2018 she called the OPP and stated that she wanted to lodge a complaint and to speak to P/C Tamminga's supervisor. P/C Tamminga called her back that night and advised her that the Crown was reviewing the file. She testified she specifically asked P/C Tamminga whether there had been a mistake and he stated there had not been. She indicated she was angry that this matter was not before the courts and he indicated he understood. She testified she made it clear to him that he could not possibly understand what she was going through. She never spoke to P/C Tamminga again but received an email the following day from P/C Tamminga indicating the Crown's office was closed and he was on marine duty. She never heard from P/C Tamminga nor S/Sgt Sakalo again.

On July 17, 2018, Ms. Lucier initiated a complaint to the OIPRD regarding P/C Tamminga's conduct. She testified she did so as she felt that neither she nor her partner had been treated fairly. The complaint was made to identify that there was something wrong with the system as this should not happen.

In early 2019 a female officer and Inspector Miller, Detachment Commander of Essex County OPP, came to her home and advised her charges could not be filed as the statute would not allow for it, given it had been too long. Ms. Lucier testified that she was upset and disappointed about this news and could not understand how someone could cause an accident of this magnitude and there be no repercussions.

Recounting the impacts on her life, Ms. Lucier testified this caused her to have continued anxiety and frustration that the person who caused the death of her partner and her life as she knew it that day, was not held accountable. The OPP did not help her and she felt that no one cared. She felt the OPP is not professional and there are no proper procedures to make sure it does not happen again. She testified she is a manager and she knows about deadlines and she questioned why there was no deadline imposed that everyone knew about.

Cross Examination

Ms. Lucier testified that she did not name S/Sgt Sakalo in her OIPRD complaint nor mention the call with him on January 23, 2018. She acknowledged S/Sgt Sakalo prepared an information note as she had received it in disclosure but she was not specifically aware of the title of the document. She was aware that S/Sgt Sakalo was involved in a number of meetings with P/C Tamminga, the Crown Attorney and Inspector Miller.

Ms. Lucier acknowledged she was aware that S/Sgt Sakalo was working in Leamington from August 2017 to March 2018. She was not aware that there was an acting S/Sgt in S/Sgt Sakalo's position while he was away. She testified that aside from disclosure outlining the reporting structure of the OPP, she felt there was some failure.

Ms. Lucier agreed she attended a meeting with Inspector Miller sometime after she made the public complaint. She did not recall any explanation by Inspector Miller as to reasons for the delay in processing charges related to her Motor Vehicle Collision (MVC).

Ms. Lucier concurred with defence counsel that a few weeks prior to the hearing she was told by Sgt Vanroboys, that *"they [the traffic unit] have a supervisor"*. Through disclosure, Ms. Lucier learned of several others that were involved in the MVC investigation including T/Sgt Martin, Sgt Blanchard, S/Sgt Quenneville and then S/Sgt Bertram. She agreed that based on her experience there appeared to be a problem with the system.

Ms. Lucier in relation to her testimony stated she contacted the OPP and left messages, Ms. Lucier concurred that she was not able to confirm that all of those messages were received by either P/C Tamminga or S/Sgt Sakalo. Ms. Lucier agreed that it was her understanding that there was no-one overseeing P/C Tamminga at the time, as the traffic unit did not have a supervisor.

Re-examination

In relation to her testimony about understanding that there is now a supervisor over P/C Tamminga's position, Ms. Lucier testified that throughout this she assumed that would have been the case but she did not know what the supervisor was called. She did not know specifically to whom P/C Tamminga was accountable. In relation to her comment about the OPP system having problems, she testified that she was not aware until June 2018 if it was

systemic issue or a problem with the officer.

P/C Rene Tamminga - OIC

Evidence in Chief

P/C Tamminga testified that he has been a police officer for 31 years, first in Toronto, then Chatham-Kent and with the OPP since 2002. In April 2017 he was part of the Essex County TMU and his supervisor at the time was S/Sgt Sakalo. In his testimony he requested that any evidence he provided not be held against him. He qualified his duty report and confirmed that he wrote it personally and it was entered as an exhibit¹. P/C Tamminga testified that he had no other supervisors at that time.

P/C Tamminga testified he was the OIC of this investigation on April 9, 2017 involving a collision between a motorcycle and a motor vehicle. As such, it was his duty to complete the collision investigation, maintain contact with family members of involved persons and to keep the organization apprised.

P/C Tamminga testified that he believed tha the other driver (of the motor vehicle) was the cause of the collision and that the driver had failed to stop and struck the motorcycle. He explored whether alcohol was a factor and the results indicated that the driver had a low blood alcohol reading. He testified that he believed that charges of Careless Driving were appropriate but he did not lay charges right away, *“I don’t know if it is direction or instruction but it was suggested to not lay charges right away.”* He explained this would provide an opportunity to have the Technical Traffic Collision Investigation (TTCI) report which would be instrumental to the give the investigation *“more shape.”*

P/C Tamminga testified that he completed all the required documentation that shift but there were many investigative steps remaining including obtaining the TTCI report, following up with the family and a meeting to determine the course of action. He worked the following day and continued to work on the occurrence. He made arrangements to meet the next of kin, Keith Thompson, brother of Paul Thompson as well as other family members.

P/C Tamminga learned from the family that both Paul Thompson and Ms. Lucier were on life support with very serious injuries. He testified he believed he learned about Paul Thompson’s death from family members and that he believed he notified S/Sgt Sakalo although he could not say when. He felt Careless Driving charges were the most appropriate but Ms. Lucier was upset about that charge considering she had life altering injuries and she had lost her husband. P/C Tamminga testified that these comments affected him deeply and he considered whether Dangerous Driving charges could be laid and he explored this in a meeting with a prosecutor who believed the charges could be supported although it would

¹ Exhibit 16: P/C Tamminga’s Duty Report

not be a strong case.

P/C Tamminga testified that there was a case conference meeting on May 5, 2017² in respect to the accident. He testified that he did not believe that the meeting went as planned due to other organizational needs that day. P/C Tamminga did not recall whether charges were discussed at the time. His recollection was that S/Sgt Sakalo was at the meeting only briefly. He testified that it would make perfect sense that the unit commander of the TMU would have been in attendance but at the time it was not possible. P/C Tamminga described the purpose of the meeting was to regroup and ensure the investigation was proceeding as it should, including outlining assigned duties.

P/C Tamminga recalled that Ms. Lucier attempted to contact him throughout the summer and fall of 2017. He admitted that he did not return every call. He had no intention to not follow up on this matter but it was a very busy time. He agreed he did not charge the other driver within the six month timeline for *Provincial Offences Act (POA)* matters. P/C Tamminga indicated that criminal charges were the only way to proceed at that point.

P/C Tamminga testified he had no recollection of S/Sgt Sakalo inquiring about this investigation in 2017. Further, P/C Tamminga raised no concerns to S/Sgt Sakalo. In January 2018 P/C Tamminga spoke to Ms. Lucier and on February 3, 2018 he met with her at her residence in relation to a Dangerous Driving charge that was going to be laid. She provided him an update on her injuries and he provided her a Victim Impact Statement. He testified that he did not report to S/Sgt Bertram in respect to this investigation nor to any other supervisors clarifying that S/Sgt Sakalo was not really involved in this investigation either. He did not report to Traffic Sergeant (T/Sgt) Martin nor to Sgt Blanchard.

According to his testimony P/C Tamminga charged the other driver on March 22, 2018 but the accused was not brought before the courts. At that time, P/C Tamminga had advised Ms. Lucier, but not any supervisors, that charges would not be proceeding. P/C Tamminga stated that he believed his direct supervisor at the time was S/Sgt Sakalo but *“it was a bit of a revolving door.”*

P/C Tamminga believed he had conversations with S/Sgt Sakalo about this file from January to March 2018 but only in relation to him calling Ms. Lucier. He was not certain whether S/Sgt Sakalo asked him questions about the status of the investigation but if he did, P/C Tamminga stated that he would have given him assurances that things were moving along. He spoke to no other supervisors during this time. P/C Tamminga stated that he was conflicted internally and he believed that he was receiving conflicting information as to whether it was proper to proceed. He could not identify the source of that information

² P/C Tamminga testified the case conference on May 5, 2017; this contradicted the evidence of other witnesses of May 2, 2017. I find this an error and the May 2, 2017 will be relied upon.

indicating it may have been internally or from the crown.

When questioned about to whom he reported, P/C Tamminga stated it would be the road sergeants of the day and it could be anyone who would review his Niche reports and there were sergeants who would approve briefs. P/C Tamminga stated that as a constable in the TMU, his next ranking officer was the North S/Sgt and in June 2018 that was S/Sgt Sakalo. He could not recall whether S/Sgt Sakalo addressed any concerns with him.

Various documents including emails and reports were put to P/C Tamminga in his testimony. Those documents, as well as relevant testimony related to them, will be analyzed within the *Analysis* section. Pursuant to emails presented to him, P/C Tamminga testified that he presumed he discussed the issue with S/Sgt Sakalo about the brief not being submitted yet.

He and S/Sgt Sakalo attended a meeting with the Crown Attorney on June 21, 2018 who had concerns about undue delay. He did not recall S/Sgt Sakalo's input at the meeting but that he was neutral. P/C Tamminga understood he received direction to stand down [on charges] until further notice until the Crown Attorney had reviewed the brief. He was not clear on who told him to stand down although he described it was not the Crown Attorney or a fellow officer, but rather someone in a position of authority. Once the Crown Attorney indicated issues with undue delay, it was his belief that he and S/Sgt Sakalo discussed options but he could not recall the specifics. Charges were not laid and he did not communicate this to Ms. Lucier.

Examination by Ms. Lucier

Ms. Lucier inquired of P/C Tamminga whether he or anyone at the OPP had any relationship with the other driver involved in her MVC. He testified that he did not and was not aware of anyone who did. He denied that the other driver was shown any favouritism. P/C Tamminga added that he regretted how this transpired and it is something that he cannot undo.

Cross Examination

The Notice of Hearing outlining the misconduct allegations against P/C Tamminga himself were entered as an exhibit. He took full responsibility for his failure to proceed with either POA or criminal charges. P/C Tamminga testified he did not input any timelines in Niche as a task reminder.

P/C Tamminga agreed that the north Operations Manager/ S/Sgt had operational oversight over the TMU. He testified that he would hesitate to agree that the road sergeant would have direct oversight over TMU members as they knew their roles without having someone dictate to them. He testified, "*I don't know that I reported to them*". He explained that as a traffic officer he had autonomy and independence to perform his duties. He agreed that members of the TMU had a lot of latitude and they did what they could to improve public safety.

He agreed that there was a sergeant for each shift who was responsible for that shift and that if asked to do something by that sergeant he would do it. On April 9, 2017 when he showed up at the accident scene, it was fair to say that he took direction from Sgt Blanchard and he understood that some direction had been given by T/Sgt Martin, although he had no direct contact. His recollection was that S/Sgt Bertram was the on-call Operations Manager.

P/C Tamminga agreed that in the subsequent case conference meeting on May 5, 2017 he received further direction regarding the investigation after discussions with T/Sgt Martin, Sgt Blanchard and the TTCI officer.

Although he could not recall, he believed he received an email from S/Sgt Sakalo assigning him an outstanding task. Further, he agreed that S/Sgt Sakalo was in the south manager position from approximately August 2017 to March 2018. He agreed that if he had issues with the investigation during the time Sgt Gruszka was in charge as the north Operations Manager, he would bring them to Sgt Gruszka, but he had not done so.

He agreed he had a number of work pressures at the time. In referencing his duty report, he agreed that his memory at the time would have been better. In respect to note taking, if it was in relation to a meeting, he would make notes but possibly not in relation to a brief conversation.

He testified that prior to the May 2017 case management meeting, he did not recall whether he had discussions with S/Sgt Sakalo regarding this case nor did he remember bringing any concerns forward to S/Sgt Sakalo. He did not request direction nor was direction given up until fall of 2017. He agreed he had no specific recollection about discussion of this incident with S/Sgt Sakalo up until January 2018 to June 2018.

In his duty report, defence counsel brought P/C Tamminga's attention to his comments in relation to updating Sgt Blanchard and meeting with her briefly. He testified that he had a conversation with a provincial prosecutor in September 2017 wherein he had the file and sought advice, running the scenario by him. He did not recall that T/Sgt Martin directed this MVC warranted a careless driving charge. He recalled that the assignment registry of tasks was provided by T/Sgt Martin to assist the investigation.

P/C Tamminga agreed that, with the exception of the email from S/Sgt Sakalo in January 2018 and interactions in June 2018, the only supervisors he received direction from were Sgt Blanchard and T/Sgt Martin. He further agreed he had no discussion nor direction from Sgt Gruszka.

In relation to his workload from April 9, 2017 - June 2018, P/C Tamminga agreed that he was trying to manage a significant workload and it was at a time when the detachment was short-staffed. He expressed that the amount of work accomplished by the two units [TMU

and the Marine Unit], it was deserving of a sergeant “to have their back”, noting the S/Sgt role had many other duties. He was aware of the recent advertisement for a sergeant position to oversee members of the TMU.

P/C Tamminga was referred to Exhibit 14, the contact log prepared by Ms. Lucier. He could not specifically recall that he received every message noted in the log. He agreed that Ms. Lucier made many efforts to get in contact with him and that S/Sgt Sakalo may or may not have received all of those communications.

Re-examination

P/C Tamminga agreed that he did not record every contact with Ms. Lucier in his notebook. Further, from April 2017 to September 2018 he did not record all of his conversations with S/Sgt Sakalo in his notebook.

Ms. Lise Pharand – Detachment Administrative Clerk

Evidence In Chief

Ms. Pharand outlined her responsibilities as a detachment administrative clerk including to provide administrative support to command staff and detachment personnel. She testified that she received voice messages from Ms. Lucier requesting to speak with P/C Tamminga but did not speak to her directly. She explained that generally she would send emails to the particular officer regarding the voice message and she did so on a few occasions communicating messages from Ms. Lucier to P/C Tamminga.

Several of those emails were submitted as exhibits³. In a June 18, 2018 email, she copied the email to S/Sgt Sakalo explaining that he was her direct supervisor. In a June 25, 2018 email from her to S/Sgt Sakalo she advised him of two additional messages from Ms. Lucier. She escalated the email sending it to S/Sgt Sakalo assuming that no one had returned Ms. Lucier’s email. Ms. Christina Kerr is the detachment administrative clerk who also received a phone call from Ms. Lucier. Ms. Pharand addressed the latest call in relation to Ms. Lucier wanting to go to the newspaper about the lack of communication.

Ms. Pharand testified she could not confirm the specific conversations she had with S/Sgt Sakalo but that they spoke generally about Ms. Lucier calling. Ms. Pharand testified that at the time there was no direct supervisor over the TMU and that she believed at the time it was whomever was assigned as the north Operations Manager. She confirmed that she did not include S/Sgt Bertram nor Sgt Blanchard on these emails.

Examination by Ms. Lucier

Ms. Lucier did not have any questions.

³ Exhibit 22: Emails re: Lucier calls – 8 pages

Cross Examination

Ms. Pharand confirmed she initially had no idea what Ms. Lucier was calling about but was aware that she was involved in a tragic accident. She would be aware of who the on-call Operations Manager was but would have no idea about S/Sgt Sakalo's responsibility for this matter. She included him simply because he was the person she would deal with, and to whom she reported. When questioned about the terms operational manager versus direct manager she understood the difference but she did not know who was specifically responsible. She agreed that she was not clear on the reporting relationship for P/C Tamminga at that time as there were many changes ongoing. She agreed that when she was interviewed by PSB in September 2018 she made reference to supervision as convoluted.

A/S/Sgt Erica Vanroboys – PSB Investigator

Examination in Chief

The Niche RMS Standard Operating Procedures Manual⁴ was introduced through A/S/Sgt Vanroboys and she testified OPP Orders are guidelines. A/S/Sgt Vanroboys reviewed the Responsibilities of a Supervisor for Niche RMS records. The Task Summary Report⁵ for LP17096588 was presented and A/S/Sgt Vanroboys outlined that it was in relation to the MVC involving Ms. Lucier. It indicated that P/C Tamminga was the assigned member and S/Sgt Sakalo was his supervisor on Niche.

The Task Summary Report indicated that P/C Tamminga was assigned this occurrence on April 10, 2017 and S/Sgt Sakalo approved the initial report on July 4, 2017. A/S/Sgt Vanroboys testified that the updated information from April 24, 2017, indicating Mr. Thompson died as a result of the MVC would have been visible on July 4, 2017 when the report was approved.

A/S/Sgt Vanroboys testified that she had a Niche audit⁶ conducted which indicated that after S/Sgt Sakalo approved the Niche report in July 2017, he then accessed it again on January 22 and 23, 2018, with the latter date being the last time he accessed it. Further, she testified that S/Sgt Bertram accessed the report once in May 2017 and Sgt Gruszka never accessed the report. It was her belief that S/Sgt Sakalo was P/C Tamminga's supervisor.

PSB Interview of S/Sgt Sakalo

The audio recording of S/Sgt Sakalo's compelled PSB interview on September 20, 2018 was played in full before the tribunal. I will deal with some relevant quotes throughout my analysis but in general S/Sgt Sakalo explained that he had operational oversight of the TMU

⁴ Exhibit 23: Niche RMS SOP manual

⁵ Exhibit 24: Task Summary Report

⁶ Exhibit 25: RMS Niche Audit –Excerpt

members but that members were supervised by the platoon NCO of the day. TMU members are independent workers who get direction not supervision.

He was promoted to S/Sgt late December 2016, previously he was a sergeant for five and a half years. He agreed he had taken the supervisor's course and was aware of his related responsibilities under Police Orders.

In his PSB interview, S/Sgt Sakalo stated that became aware of the situation when he was contacted by court services. At that point, he became immersed in the file. He clarified that he would approve P/C Tamminga's criminal Niche reports but he had not done a performance evaluation for him for previous years. On April 9, 2017, he was not the on-call Operations Manager and he was on Block training from April 10 to 13, 2017. He stated that he did not follow this occurrence as S/Sgt Bertram had been the on-call Operations Manager and it was his to follow. He was not part of a case consultation meeting in relation to this event.

When S/Sgt Sakalo received the chart of benchmark MVCs requiring action in January 2018 he sent it to the responsible members. He stated that he would have had conversation with P/C Tamminga about the case but could not recall the specifics. He may have sat in on the May 2, 2017 case conference meeting wherein T/Sgt Martin directed P/C Tamminga to lay a careless charge. He had to leave the meeting due to issues related to the death of a detachment member.

On January 23, 2018 S/Sgt Sakalo spoke with Ms. Lucier about her frustrations about a lack of charges with P/C Tamminga and following that call he sent an email to P/C Tamminga with a copy to Sgt Gruszka who was the north Operations Manager at that time. S/Sgt Sakalo indicated he was an acting south manager from late August 2017 to February 2018. In his interview, S/Sgt Sakalo stated, ultimately, he as the TMU manager, is responsible for what his members do.

The problems with the file only came to his attention "*late in the game.*" To him P/C Tamminga was an experienced officer and S/Sgt Sakalo stated that he still has never been provided an explanation from him and that "*.... something was preventing him [P/C Tamminga] from finishing this and I am not aware of what that is.*" He has never had a conversation with P/C Tamminga regarding his caseload. He has never had any issues with P/C Tamminga completing his investigations before.

On July 6 and 9, 2018 S/Sgt Sakalo met with P/C Tamminga who was going to look after getting the file done "ASAP". P/C Tamminga was given a diary date of July 13, 2018 but it was not formally followed up on. S/Sgt Sakalo stated that P/C Tamminga was coming in that day (date of interview) to provide an update.

Resume testimony

After the completion of the audio interview, A/S/Sgt Vanroboys responded to questions about the role of the West Region Traffic Team, specifically T/Sgt Martin. She testified this unit provides support and guidance but does not take over the investigation nor are they there in a supervisory capacity. She received a duty report from Sgt Blanchard. A/S/Sgt Vanroboys testified that it was her understanding that if something happened while on shift they [a platoon sergeant] would provide assistance and guidance but Sgt Blanchard was not P/C Tamminga's supervisor.

Examination by Ms. Lucier

A/S/Sgt Vanroboys explained that she found S/Sgt Sakalo was P/C Tamminga's supervisor and she had formed reasonable and probable grounds to believe that a neglect of duty had taken place and that is the reason for this hearing.

Cross Examination

A/S/Sgt Vanroboys stated that she did not review the on-call policy as she believed that was a different issue. She testified that she did not believe that whomever took the call, keeps the call. She did not review the on-call policy although she agreed both S/Sgt's Sakalo and Bertram were operating under that policy.

A/S/Sgt Vanroboys' investigative report⁷ was put before her and she agreed it appeared to be most of what she wrote. A/S/Sgt Vanroboys agreed that demotion for both S/Sgt Sakalo and P/C Tamminga were suggested penalties. This was a benchmark collision regardless of whether a person passed away and the responsibilities for the Operations Managers did not change.

A/S/Sgt Vanroboys agreed with the importance of the OPP providing its members tools to do the job. Niche is one of those tools but A/S/Sgt Vanroboys was not aware of a benchmark collision template. She testified that in the course of her investigation, she reviewed everything that was on Niche and she agreed that it was possible that there may be tasks associated to this occurrence that may have been signed off by other supervisors or a Second In Command (2IC). A/S/Sgt Vanroboys agreed any supervisor could sign off a task but she was not aware that that had been done by any other supervisor. A/S/Sgt Vanroboys disagreed that Niche was always dependent on the input of the officer for a supervisor to have something to review. She clarified that a supervisor could assign a court task and they could also review the report itself to determine action taken.

When questioned about the terms 'operational oversight' versus 'direct supervision', A/S/Sgt Vanroboys stated that P/C Tamminga would not have face to face, direct supervision by S/Sgt Sakalo every shift he worked.

⁷ Exhibit 28: PSB Investigative report

A/S/Sgt Vanroboys agreed that S/Sgt Sakalo was not the north Operations Manager from August 2017 to March 2018 but when she did the Niche audit for this occurrence she did not find Sgt Gruszka at all in the audit. A/S/Sgt Vanroboys agreed that the supervisor who assigned a task would be responsible to ensure that task was completed. She agreed that the Niche audit shows that S/Sgt Sakalo's access to the report on January 22, 23, 2018 accords with the date he had a conversation with Ms. Lucier.

The case conference meeting was May 2, 2017 and T/Sgt Martin and Sgt Blanchard were there but A/S/Sgt Vanroboys disagreed that at the meeting, T/Sgt Martin gave direction to lay careless charges as the TTCl report had not been received yet. She characterized T/Sgt Martin as giving support. She characterized the meeting as a discussion not direction. P/C Tamminga was directed to hold off on charges until the TTCl report was completed and she agreed that would be considered "*direction.*" A/S/Sgt Vanroboys testified that there was no evidence that either T/Sgt Martin nor Sgt Blanchard followed up on charges after the TTCl report was completed in August 2017.

A/S/Sgt Vanroboys agreed that there was no evidence that either S/Sgt Sakalo or S/Sgt Bertram received an email notification of Mr. Thompson's death, but she clarified that the sudden death report was on the occurrence report at the time S/Sgt Sakalo checked it in July 2017. She agreed S/Sgt Sakalo was made aware of issues with the file by court management personnel, Ms. Sivell, on June 12, 2018 and then in a June 20, 2018 email; there was a decision communicated that the OPP would not be engaging in discussions about this case outside of the court process.

In relation to S/Sgt Bertram being the responsible supervisor at the time on April 9, 2017, A/S/Sgt Vanroboys agreed S/Sgt Bertram did not submit a duty report as, after a phone conversation with him, he indicated he had nothing to do with the investigation. She did not ask him why he looked at the Niche occurrence on May 22, 2017. She later interviewed S/Sgt Bertram in May 2019 after the investigative report had been completed. A/S/Sgt Vanroboys agreed that S/Sgt Bertram acknowledged he was the on-call case manager for this incident. Further, in response to her question about the expectation that the case manager would follow these investigations, S/Sgt Bertram stated that he would monitor these investigations.

Exhibits 29 and 30 refer to the audio interview and related transcript of A/S/Sgt Vanroboys interview with S/Sgt Bertram on May 28, 2019. The interview was played in full and is referenced below under the testimony of S/Sgt Bertram.

S/Sgt Stuart Bertram – On-Call Case Manager April 9, 2017

Evidence In Chief

S/Sgt Bertram testified on June 27, 2019. He was the on-call S/Sgt/ case manager on April

9, 2017, the date of the accident. In April 2017, he was the south Operations Manager in Essex County, working out of Leamington Detachment. He left in September 2018 for another position but had done some acting time away from his home position prior to that time. Although there were four S/Sgt's working in Essex County, he and S/Sgt Sakalo were the Operational Staff Sergeants.

S/Sgt Bertram testified that the TMU in Essex County was a team of constables under S/Sgt Sakalo's responsibility. Although there was no sergeant in that unit, there was a 2IC. S/Sgt Bertram testified he never supervised members of the TMU nor P/C Tamminga. In relation to his responsibilities as the on-call operation manager:

...if necessary, liaise with the other Operations Manager if there were any questions or concerns or things that weren't explained in the notification to them. But after that I didn't necessarily have responsibility. That staff sergeant would then, it would fall under their purview of responsibilities.

My belief is that I am in charge of my officers. If somebody reported to another staff sergeant then that was their responsibility. I was of the opinion that we tried to maintain simple reporting guidelines for ease of the officers so they didn't get confused as to who they reported to.

Portions of S/Sgt Bertram's PSB interview were read into the record during his testimony however the audio interview in totality was played in the course of PSB investigator, A/S/Sgt Vanrobey's cross examination. I have noted relevant statements below and considered them within my analysis.

In his interview on May 28, 2019, S/Sgt Bertram stated that he never had any conversations in relation to this investigation with P/C Tamminga, S/Sgt Sakalo or anyone else. Further, he stated that P/C Tamminga's direct ranking supervisor was S/Sgt Sakalo. It was for this reason that he did not follow this investigation as P/C Tamminga was under S/Sgt Sakalo's supervision. If it had not been P/C Tamminga then he would have followed this investigation, if he had been notified that the driver had passed. He stated as the MVC occurred in his area of jurisdiction then he would be responsible as it would be one of the officers who reported to Sgt Blanchard.

S/Sgt Bertram testified he was aware from a West Region Strategic Leadership conference on October 19, 2017 that benchmark MVCs were ultimately the responsibility of the Operations Manager/ S/Sgt. When questioned about what he meant when he stated, in his PSB interview that, "*if it had been a fatality [he] would have followed it?*" S/Sgt Bertram stated he would have followed up with the investigation, ensured that Sgt Blanchard was moving the investigation forward and if no [case conference] meeting had taken place then he would have looked to arrange one.

Further, in his testimony, he was asked to comment on his understanding, if he was aware this was a fatality and it occurred in Kingsville, as to whether he would have been the case manager and whether he would have believed that he was responsible for P/C Tamminga, S/Sgt Bertram testified,

“I think he would have been reporting to his Sergeant (Blanchard) who would then I would be looking after so I would be responsible for the investigation to its conclusion, yes. I wouldn't say that Constable Tamminga would be reporting to me be but.”

The prosecution referenced Sgt Blanchard's duty report and questioned S/Sgt Bertram specifically about content therein. In respect to Sgt Blanchard's comment that P/C Tamminga is a member of the TMU and she had no direct supervisory responsibility for him, S/Sgt Bertram testified that P/C Tamminga does report to Sgt Blanchard on a direct supervision basis; there is a reporting structure that takes place if there is an investigation in her area of responsibility.

In questioning S/Sgt Bertram in respect to Sgt Blanchard's duty report wherein she noted she did not approve his schedule, time-off, crown briefs or RMS reports, S/Sgt Bertram testified that he believed that to be correct. He testified S/Sgt Sakalo would still have a role as P/C Tamminga's direct supervisor and they would be keeping each other up to date as it involved an officer who reported to S/Sgt Sakalo but the MVC occurred under S/Sgt Bertram's jurisdiction.

Examination by Ms. Lucier

S/Sgt Bertram agreed that he supervised Sgt Blanchard at the time of the MVC but that she never reported that Mr. Thompson passed away. Ms. Lucier questioned S/Sgt Bertram about his understanding that this was not a fatal and so it was not of importance to him. He stated that was not the case; he was satisfied that all the needed resources were involved. He testified that P/C Tamminga's role was to cover the county.

Cross Examination

S/Sgt Bertram testified that Sgt Blanchard would have had responsibility for criminal charges and to ensure they were laid. She was responsible for the successful conclusion of the investigation as this took place in Kingsville and she was the supervisor on duty at the time of the accident. This investigation took place in an area over which he had supervisory responsibility.

He testified that as a sergeant he was the supervisor of a unit, the Provincial Liaison Team. He described a matrix reporting relationship to a S/Sgt position out of GHQ and additionally to the West Region Command Staff. Part of this reporting structure involved relevant updates. S/Sgt Bertram agreed it was part of his duties to notify the chain of command.

S/Sgt Bertram agreed with defence counsel about Niche report approvals and that although as an Inspector he may approve and sign off a task of a S/Sgt that may report to him, he would not be aware of all of the activities of the S/Sgt. S/Sgt Bertram disagreed with defence counsel that although a frontline officer may not report directly to him, he may still sign off on a Niche task. S/Sgt Bertram testified that although his knowledge of Niche was limited, tasks of a frontline officer would go to the officer's assigned sergeant.

In his testimony in relation to Niche tasks, S/Sgt Bertram stated that it was not his experience that other sergeants can approve other sergeant's tasks. S/Sgt Bertram agreed that with his limited Niche abilities, that the statement "*unless an officer enters activity and includes a specific task then you would not be aware of that activity*" as "*seems correct.*"

In respect to the terms operational oversight versus direct management, S/Sgt Bertram testified, generally his role as a staff sergeant at the time would be characterized as operational oversight. On April 9, 2017 as the S/Sgt, he agreed that he had no direct reporting with frontline constables and that his reporting relationship was with his sergeants who would bring issues forward to his attention. In relation to Sgt Blanchard, S/Sgt Bertram agreed that it was his expectation that she would have brought to his attention that Mr. Thompson died but that did not happen.

He agreed that the OPP is a hierarchical organization and in order to function effectively and efficiently everyone must fulfill their responsibilities and if that is not the case then the chain of command breaks down.

S/Sgt Bertram agreed that his higher level in the organization creates higher expectations and as a supervisor, one sets an example for the people below them. In respect to the on-call system in place on April 9, 2017, S/Sgt Bertram testified that Inspector Miller was aware of the on-call system although he did not recall any approval from him. However, S/Sgt Bertram agreed that he would not have participated in the on-call system if Inspector Miller had not agreed it was appropriate. It was only he and S/Sgt Sakalo who took on-call duties at the time, as they each had the requisite experience. 'On-call' was not officially 'on-duty', as it should only require a response to an on-call matter. The on-call system was for the hours after 4:00 pm on weekdays and for weekends. It is an informal agreement without financial compensation; only at times was it compensated by overtime.

S/Sgt Bertram testified the on-call person covered all of Essex County and the notification would come via a telephone call or an email. He agreed that benchmark MVC's involved fatal or serious injuries. Exhibit 17, the email from Sgt Blanchard notifying numerous members of the "*serious car vs MC collision*", "*male driver VSA, female passenger leg severed*" and he agreed this meets the definition of benchmark MVC. S/Sgt Bertram agreed that based on this email, he assessed that no further action was required.

In relation to his examination in chief wherein he identified that the wellness of officers was also his responsibility. He agreed this was a very serious collision and officers' health and wellbeing could be impacted; he agreed he did not take any further action. He kept the email as record of the event but agreed that he probably should have made a notebook entry.

Defence counsel referred to S/Sgt Bertram's PSB interview transcript and related portions of the audio recording was played for the tribunal. In the PSB interview, S/Sgt Bertram agreed that initially as the on-call S/Sgt it would be his responsibility to monitor the benchmark MVC and further, to ensure it was properly processed and all required resources were provided. As the Operations Manager, if there were further developments in that event and he was still on-call then he would expect to get updates if they were significant.

S/Sgt Bertram agreed that continuity of oversight is important in any type of benchmark investigation. S/Sgt Bertram agreed that even when no longer on-call, there were occasions when he continued to monitor, if the matter was in his area of responsibility. In his testimony, S/Sgt Bertram advised that he would advise the next person on-call or the person who had responsibility but given who was on the email [notification] he felt no need to duplicate an email to advise his counterpart.

He was questioned about whether, when one stops being on-call, given there is an outstanding benchmark MVC would it not be a responsibility as an Operations Manager to advise the next person on-call or advise the person who has jurisdiction. S/Sgt Bertram stated that he would have, had the other person not been on the email. He agreed that he had no way of knowing if anyone other than he had read the email but that if he forwarded the email on, he also would have no way of knowing it was read. S/Sgt Bertram testified that he believed the on-call process began in January 2016 and that if the other Operations Manager was out of town, they would be notified but he could not recall such a 'hand-off' being done in this incident.

When pointed out by defence counsel that this matter was in his area of jurisdiction and according to his testimony, would that not make him responsible for overseeing this matter, S/Sgt Bertram agreed. He further agreed that after April 9, 2017, if updates were required on this matter then Inspector Miller would look to him [S/Sgt Bertram] for those updates.

A/Inspector Andrea Quenneville

Evidence in Chief

A/Inspector Quenneville stated that in January 2017 she was promoted to Unit Commander of Highway Safety Division (HSD), (S/Sgt role) responsible for overseeing five sergeants, 29 constables as well as managing the Provincial Safety Initiative, marine and motorcycle including anything traffic-related within West Region. She was also the regional liaison to

Provincial Traffic Operations out of Orillia.

In respect to benchmark collisions where there was either a fatality or injuries that were life threatening or life altering in nature, she was notified through the Provincial Operations Centre (POC) or through one of the five traffic sergeants she managed. These communications were primarily through emails.

A/Inspector Quenneville described that the Operational Managers at detachments were the case managers of benchmark collisions. This process had been in place since she started the position in January 2017. The language of 'case manager' comes from Major Case Management (MCM) principles. As the case manager, one had oversight of the entire investigation and ultimately, the decision on the speed, flow and direction of the investigation.

In relation to whether Operational Managers were expected to partake in any meetings regarding benchmark collisions, A/Inspector Quenneville testified:

Following a benchmark collision it would be expected practice that the T/Sgt would initiate an initial case conference so that meeting was expected to take place within 24-48 hours from the collision. It was expected that the Operational Manager or their designate would be either in attendance physically there or call in for the preliminary meeting where discussions were had about the course of the investigation and preliminary evidence that we had and resources personnel that need to be assigned, to do the investigation.

Further she outlined the purpose of this meeting was:

To ensure that a lead investigator was assigned, that actions were assigned;...its major case management language but basically it means that the tasks or to-do list, that priorities were set and to evaluate the initial findings; the initial witness information, initial scene information, whether there was any medical updates, or what our reconstructionist or technical investigators, what they could tell us in the early stage as well.

A/Inspector Quenneville testified the responsibilities of the Operational Manager in relation to follow-up with the investigator were both proactive and reactive and:

...[after the initial case conference] it was left after that to the Operational Manager to have oversight of the investigation. So oversight of the investigation would include having contact with those officers that were the lead or the file.

A/Inspector Quenneville explained her understanding of the term 'oversight of investigation'

to mean having an understanding of every aspect of the investigation. Her role as unit commander was to support these investigations which may mean touching base to find out how they were doing and if there were resources required or identified concerns with the investigation.

A/Inspector Quenneville testified that ultimately the Operations Managers at detachment were responsible for these benchmark collisions. This was the process for West Region as per the direction of West Region Command but there were different practices across the province. She opined that this process was challenging for Operations Managers. She testified that this practice was communicated to the Operations Managers prior to her start in January 2017 but she was advised through Strategic Leadership Conference in 2016 that the Regional Traffic Manager, Lisa Anderson and West Region Command had communicated that to the Operations Managers in West Region.

A/Inspector Quenneville testified that she was aware S/Sgt Sakalo was an Operations Manager in April 2017 as she had a conversation with him on April 19, 2017 in relation to that role, although she had contacted him to discuss a *different* benchmark collision that had happened weeks before in Essex County. She referred to her notes about a conversation she had with S/Sgt Sakalo. His role and responsibilities as case manager were discussed as there were a number of assignments from that [other] investigation that were still outstanding. She asked S/Sgt Sakalo to have a review of the particular occurrence as she was concerned about the charges being considered. She testified that S/Sgt Sakalo expressed a concern about the number of assignments that were part of the assignment register. She went on to explain the *Natsis*⁸ recommendations and why the OPP was investigating benchmark collisions in that manner and the need to improve consistency. She recalled identifying that he was the case manager for that occurrence but she could not recall whether she went into great detail about what that meant. S/Sgt Sakalo questioned her asking, “*who says I am the case manager?*” and she replied that West Region Command did. She could not recall whether she reviewed the role of the T/Sgts nor whether S/Sgt Sakalo had any questions about his role as case manager.

A/Inspector Quenneville testified that she was not the case manager for the benchmark collision involving Ms. Lucier; her [A/Inspector Quenneville’s] direction had been, that it was her role and that of her five T/Sgts to provide support for these collisions. T/Sgt Martin who reported to her, was involved in the Lucier MVC but he was never the case manager nor was he ever responsible for the oversight of this collision as that was not his role. T/Sgt Martin’s role, as part of the Highway Safety Division team, was to provide support to detachments, not to ensure court processes were completed.

⁸ *NATSIS* recommendations came as a result of a court decision & involved the need for case management of serious MVC incidents.

A/Inspector Quenneville testified that on January 19, 2018, she sent out the list of benchmark collisions⁹ requiring administrative or investigative follow up, to assist Operations Managers with benchmark occurrences. Her expectation was that the Operations Managers would review the list and assign follow up. In relation to the MVC on April 9, 2017, she testified that it was reasonable for her to think that some resolution had occurred, as it showed the driver had been charged. She testified that she received notification of all benchmark collisions but she was not aware of others wherein charges were not laid due to pre-charge investigative delay. At no time following the conversation with S/Sgt Sakalo in April 2017, did he reach out to her again in relation to assistance with benchmark collisions nor in relation to the Lucier MVC in particular. A/Inspector Quenneville opined that she felt the practice at the time was challenging for Operations Managers.

Examination by Ms. Lucier

Ms. Lucier inquired of A/Inspector Quenneville about the audit and she responded that the audit showed that a charge had been laid and in her mind the investigation was done, as a charge had been laid; she did not delve any deeper in respect to each occurrence.

Cross Examination

In relation to the email she sent out on January 19, 2018 containing the spreadsheet of benchmark collisions A/Inspector Quenneville clarified that she sent it to all of the Operations Managers in Essex County, not because S/Sgt Sakalo was P/C Tamminga's supervisor. It was a list of outstanding items sent to command staff to ensure follow up. This was the first such list she had sent out since assuming her position. She agreed that at that the time she sent her email, she had no awareness of who had operational responsibility for that matter.

A/Inspector Quenneville testified that she would not know if anyone took responsibility, as that obligation fell on the Operations Managers. She was aware that in detachments where there is more than one S/Sgt, an on-call system is used. A/Inspector Quenneville testified that changes for benchmark collisions took place in April 2019 as part of a provincial roll-out to ensure consistency across the province. This was as a result of the *Natsis* recommendations in respect to case management. Generally, now a T/Sgt would be responsible as the case manager. Further, she agreed that although it was too early to tell, the expectation is that the new system will be a more effective and efficient process.

Redirect

A/Inspector Quenneville testified that in her opinion, there were no issues with how benchmark MVCs were investigated in 2017.

⁹ Exhibit 32: Email chain – Akel, Sakalo, Gruszka / Exhibit 35: Email re Benchmark Collisions – 19January2018

Sgt Mike Gruszka (evidence was in relation to his role as A/S/Sgt but he will be referenced as Sgt throughout this decision)

Evidence In Chief

Sgt Gruszka testified that in August 2017 he took on an acting role as the north Operations Manager while maintaining his responsibilities as the Contract Manager. This acting assignment ended in March 2018. There were many conversations with S/Sgt Sakalo regarding this role around this time although he could not recall any conversations in relation to outstanding case management files. He was never assigned any benchmark MVC's that had occurred prior to him starting in this temporary position.

He testified that benchmark MVC's would be the responsibility of the on-call case manager or depending on the conversations, would have been the responsibility of the manager overseeing the jurisdiction where it occurred. If S/Sgt Sakalo had been leaving the county, then a discussion would have taken place in relation to any outstanding files. He was not part of any conversations nor certain what happened to S/Sgt Bertram's outstanding files when he left his position in August 2017. Sgt Gruszka testified that the member responsible for investigating the collision was responsible for taking the lead, ensuring it was investigated thoroughly and laying the appropriate charges. The case manager or Operations Manager had overall oversight of the investigation, ensuring the investigation was thorough and complete.

Sgt Gruszka testified that as north manager, if he was notified of a MVC he would ensure notifications were made, attend a case conference, discuss the incident with members involved and ensure the investigation is complete, charges are laid and the reports are completed. If one of his members was responsible for a benchmark MVC, he testified that he, as a direct supervisor, would work with that officer, making sure the investigation is on track and complete.

He testified that he would report up the chain of command and report the progress of the investigation and would review the Niche report ensuring all the information was accurate; he would send the report back for follow up if there were deficiencies. The responsibility for an Operations Manager would end when the case was completed in court, if charges were laid.

Sgt Gruszka testified that while he was the acting north Operations Manager that there was no sergeant; he was the direct supervisor for the officers during his tenure. He became aware of this particular case, after his acting assignment, through discussions with S/Sgt Sakalo and was aware that P/C Tamminga was the OIC. There was no such discussion while he was the acting north Operations Manager. He testified that S/Sgt Sakalo was P/C Tamminga's supervisor at the time and he was not asked to oversee any files that happened

prior to his tenure as the north Operations Manager.

Exhibit 32, a chain of emails entitled “*Benchmark Collision Review 2017*” was presented to Sgt Gruszka. He recalled receiving the email from A/Inspector Quenneville and he focused on the incidents that occurred after he started his assignment, from August 2017 onward.

Examination by Ms. Lucier

Sgt Gruszka testified that as a case manager, such cases take a while for the investigation to be completed, given TTCI reports and crown consultations may occur; however without considering the issue of toxicology, typically, they would be wrapped up within four to six months. When questioned about how often he would communicate with the investigating officer in respect to those cases, Sgt Gruszka testified that not much time would go by without some dialogue about the case. Anyone involved in a case should have “*eyes on it.*”

Cross Examination

Sgt Gruszka testified that, after leaving his acting position, he had maintained oversight over a particular benchmark MVC that had occurred when he was on-call. Further, he agreed that he understood that when, on-call you were responsible unless you handed off the case to another S/Sgt. He agreed that the responsibilities for sergeant to staff sergeant varied and as a sergeant one would have direct supervision over a platoon and that a staff sergeant would broader oversight status.

Sgt Gruszka agreed Niche tracked activities are dependent on the officer entering information but elaborated that someone should be engaged and working with the officer to know what was occurring as well. He agreed that as the on-call S/Sgt, one primarily relied on the traffic officer to put information into Niche in order to be aware of activity. He agreed that as the S/Sgt he would have knowledge and may request the officer add something to Niche. This may be done with the officer directly or by going to the supervisor or copy the supervisor.

He testified that he recalled a general meeting with S/Sgt Sakalo when he took over duties as the north manager and that the conversations were more as a mentor; S/Sgt Sakalo was a great help in guiding him but he did not recall specific cases being discussed.

Sgt Gruszka testified that as an Operations Manager he would rely heavily on the sergeant at the scene and the T/Sgt to provide their experience and guidance in the first 24-48 hours. If an officer in the TMU had issues, depending on the issue, Sgt Gruszka agreed the officer could go to the T/Sgt who may have more expertise. Although the S/Sgt is the case manager, he would not hesitate to have a TMU officer engage with a T/Sgt. The T/Sgt may provide the OIC a task list which is not always populated on Niche. In his experience as the

S/Sgt over the TMU, the 2IC, Platoon Sergeant of the day or another S/Sgt could approve a Niche task.

In relation to the on-call process, Sgt Gruszka agreed that if a call came in while on-call, although it was not in his area, he would be responsible. Further, he agreed that if, due to workload or jurisdiction, the case was to be 'handed off', then there would be a specific conversation about that 'hand off'. To his knowledge, this on-call system was still in effect.

He agreed that as acting S/Sgt, the TMU member worked in different locations and one could go 'stretches of time' without seeing those under his supervision. TMU members have the primary function to lead traffic initiatives within the county and their jurisdiction area is broad. He agreed that if the TMU officer's home base was in the north and they are at a scene in the south, then the sergeant at scene would have direct supervision.

Re-examination

Sgt Gruszka testified that as acting north manager, the 2IC could approve Niche entries of TMU members and his direction to the 2IC was that he should be alerted for any reports that required his approval, typically more serious matters such as a benchmark MVC.

He clarified that in respect to supervision at a scene, it would be that day and the first 24 hrs that supervisors would have direct supervision but after the 'dust settles' then the supervision would now fall under their direct supervisor. For the TMU that was the S/Sgt.

Sgt Tracey Blanchard

Examination in Chief

Sgt Blanchard testified that she has been with the OPP for 26 yrs. She became a sergeant in 2007 and her current role is a platoon supervisor out of Kingsville. In April 2017 she was in that role, her direct supervisor was then S/Sgt Bertram.

She was the supervisor at the MVC involving Ms. Lucier. She was not the direct supervisor for P/C Tamminga. She notified command staff as it was a serious collision although it was not a fatality at the time. The TICI officer arrived and did his work. P/C Tamminga was at the scene and offered to investigate the accident which she accepted, as she was short-handed on her shift that day. She coordinated the resources at the scene and sent officers to the hospital. She believed that S/Sgt Bertram was the on-call Operations Manager that day but she notified all command staff via an email.

She later was involved in a case conference. Sgt Blanchard identified an email chain with the date April 24, 2017¹⁰ from T/Sgt Martin to S/Sgt Sakalo, herself, P/C Root, P/C

¹⁰ Exhibit 37: Email 09April2017 – 24April2017

Tamminga and A/Inspector Quenneville regarding the case conference. Sgt Blanchard testified that she was at the case conference on May 2, 2017 along with P/C Tamminga, P/C Bortelon (TTCI), T/Sgt Martin and S/Sgt Sakalo was in and out of the room. The meeting was to discuss the Lucier MVC. She had no further involvement in this occurrence after this meeting.

She has never been P/C Tamminga's supervisor. She does not approve his Niche reports, time off nor complete his Performance Learning and Development Plans (PLDP's). P/C Tamminga was seldom on her shift and Sgt Blanchard testified that the platoon supervisor does not supervise the TMU members unless, for example, there was an arrest of a person while following her shift. She testified then if there was follow up in relation to the arrest, their TMU supervisor would look after it and the same applies to benchmark MVCs. Sgt Blanchard testified that she managed the scene of the collision and completed her responsibilities for that scene.

Examination by Ms. Lucier

Sgt Blanchard testified that when she sent the email notifying of the accident, S/Sgt Bertram called her and they had a discussion to ensure she had everything she needed and next steps. Sgt Blanchard testified that she and S/Sgt Bertram did not discuss the case on further occasions and this would be a normal process.

Cross Examination

Sgt Blanchard disagreed with the testimony of S/Sgt Bertram that she was responsible for seeing this investigation through. She concurred that she had no notes regarding her conversation with S/Sgt Bertram the night of the incident and for the day of the case conference simply noting that she attended. It was S/Sgt Sakalo that requested she attend the case conference although she has no email in relation to that request.

In respect to P/C Tamminga's involvement, she confirmed he was the OIC of this collision but could not recall if she directed this assignment or he offered. Sgt Blanchard testified that if a TMU member was working and there was a serious collision then she would expect the member to attend.

In terms of attending the hearing, Sgt Blanchard denied inquiring if she was required for the hearing but that A/S/Sgt Vanroboys asked about her availability. Around the end of June 2019, she spoke with the prosecutor and learned her name was being discussed at the hearing and she undertook an email search. The series of emails she provided do not include an email from S/Sgt Sakalo asking her to attend the case conference, as she had noted in her duty report. She did not have any further emails but it is very likely there could have been other emails.

Sgt Blanchard agreed that over the past two years she has had the opportunity to act as an

Operations Manager. She advised that it is her understanding that the north S/Sgt, responsible for traffic and marine has responsibility over fatal MVCs, unless the on-call S/Sgt takes ownership of it. When questioned about whether the on-call S/Sgt has oversight of those calls received when one is on-call, Sgt Blanchard testified that it could work like that but there are no hard and fast rules. She testified that as the on-call S/Sgt you are the contact person for any resources, advice or inquiries. Asked if minimally one would have the conversation with the person it is being 'handed off' to, Sgt Blanchard agreed that would be done as well as updating the detachment commander. She testified that she could not say definitively if she spoke to S/Sgt Sakalo or S/Sgt Bertram that night on April 9, 2017.

Re-examination

Sgt Blanchard testified that she believed it was the complaint that was filed by Ms. Lucier that prompted S/Sgt Bertram to call her to inquire about any emails she had in relation to a command staff notification regarding this incident.

In respect to any potential court proceedings, in relation to this incident, Sgt Blanchard testified that she would not have been required as a witness in court proceedings if the other driver plead guilty nor would she be required if P/C Tamminga did not file charges.

Through September to December 2018, Sgt Blanchard assumed A/S/Sgt duties in Essex County. There are two levels of T/S/Sgt, the Regional one and in Essex County there is a S/Sgt of traffic and marine overseeing the TMU. The TMU was created and supervised by S/Sgt Sakalo. There was no sergeant in the TMU in 2017 although they are now implementing a middle person.

Recall of Witness, A/S/Sgt Vanroboys

Defence counsel questioned A/S/Sgt Vanroboys about a conversation with Sgt Blanchard wherein she indicated, essentially that she was being "*thrown under the bus*". A/S/Sgt Vanroboys testified that Sgt Blanchard indicated to her that the source of this information was in relation to S/Sgt Sakalo returning from the first hearing dates, indicating the OPP was going to owe him an apology.

Documentary Evidence

Various email chains were submitted as evidence as well as several policy documents and PSB interview transcripts. I will refer to specific documents and their impacts on my analysis under that section, *Analysis*.

PUBLIC COMPLAINANT

Ms. Lucier declined to call any witnesses.

DEFENCE

S/Sgt Sakalo

Examination in Chief

At the outset, S/Sgt Sakalo responded to comments attributed to him in relation to the OPP owing him an apology according to Sgt Blanchard's report to A/S/Sgt Vanroboys. He denied making any such statements. He stated that outside of his Ontario Provincial Police Association representative he has not discussed this case with anyone at detachment.

S/Sgt Sakalo testified that he supervised over 50 members including civilians, constables and sergeants. He estimated this included approximately 45 constables. He testified that the marine unit and the mental health unit and ERT members assigned to Essex County do not have dedicated sergeants. He explained both he and the other staff sergeants are on an administrative schedule meaning weekdays with weekends off. The TMU and Marine Unit are not on administrative schedules; those members work over a '24/7' time period and they align with the four platoons across Essex County. He testified that it was impossible to have direct supervision over these individuals as he did not have the same schedule. Those members have direct supervision by the supervisors that they are assigned to work with.

Exhibit 41 refers to a generic job description for a S/Sgt role although it is not specific to Essex Detachment. S/Sgt Sakalo outlined points including under "*Accountability*" it notes the direct supervision and "*indirectly manages constables,*" the latter term would make reference to the TMU.

S/Sgt Sakalo was not on duty nor the on-call Operations Manager on April 9, 2017 at the time of the benchmark MVC in question. The on-call protocol, although not formal, is that he and S/Sgt Bertram both took after-hour calls in relation to benchmark MVCs. S/Sgt Bertram was on-call at the time of this incident and this was his [S/Sgt Bertram's] case to manager. The on-call process had the official approval of Inspector Miller and the purpose was to provide operational oversight 24 hours a day to Essex County. There was no compensation for being on-call after hours. He has never had occasion to 'hand off' or transfer an on-call incident to another Operations Manager.

In relation to this incident, S/Sgt Sakalo agreed with S/Sgt Bertram's evidence that Sgt Blanchard would oversee this matter until conclusion. Although he oversees the TMU, S/Sgt Sakalo testified that not all benchmark MVCs come to him. While one is the on-call Operations Manager, you would have ownership of that occurrence. S/Sgt Bertram never advised that the fatal MVC had occurred nor that he wished for S/Sgt Sakalo to take over.

In terms of the role of T/Sgt Martin, it was S/Sgt Sakalo's expectation that, if he [T/Sgt Martin] had any expertise to offer to either P/C Tamminga or Sgt Blanchard at the case conference, he would do so. Following that meeting, he would also expect T/Sgt Martin to be engaged

until the file was completed. He stated this was his experience at every other benchmark MVC over which he had operational oversight.

In reviewing the April 2017 case conference emails with T/Sgt Martin and P/C Tamminga in relation to a case conference, S/Sgt Sakalo stated that he was the Operations Manager in charge of the TMU and his member was to have a case conference and so he was there to support the member, in this case, P/C Tamminga. S/Sgt Sakalo testified that he is not certain why T/Sgt Martin sent him the email, as he was not the case manager. Further, S/Sgt Bertram was not on the email chain but S/Sgt Sakalo testified he was not certain why that was the case.

Further he noted, when the case conference date was being discussed, it was his intention to cover two benchmark MVC cases on the same date as they involved similar officers. S/Sgt Sakalo testified that he is unaware if S/Sgt Bertram was notified of the case conference; he [S/Sgt Bertram] was not there but he did not know why.

On April 24, 2017 P/C Tamminga sent an email to T/Sgt Martin, Sgt Blanchard, S/Sgt Sakalo, P/C Root, Inspector Miller and A/Inspector Quenneville advising Mr. Thompson had passed away.

S/Sgt Sakalo testified that on May 2, 2017, the date of the case conference, a member had died by suicide the previous day and he was not able to stay long at the case conference meeting. He testified that his attendance was in relation to another benchmark MVC not the April 9, 2017 MVC. He stated his role as case manager was to look for gaps and ensure resources were available and to help with moving the investigation along.

On January 19, 2018¹¹ A/Inspector Quenneville sent an email in relation to benchmark MVCs that were required action. S/Sgt Sakalo testified that on January 22, 2018, he forwarded the email out to the members identified as responsible for the outstanding work, with a copy to their supervisors. The MVC involving Ms. Lucier was on the email and S/Sgt Bertram was a recipient on the original email chain.

Exhibit 25 is a Niche audit excerpt; S/Sgt Sakalo explained this was likely in relation to him checking reports when Ms. Lucier was calling the detachment. He wanted an overview and understanding of why she was calling. The audit indicated when he went into this incident and opened the various folders.

S/Sgt Sakalo explained that he approved the initial task on Niche. Some days, he would have hundreds of Niche reports to approve and so it would be impossible to conduct an in-depth review of each one. He testified that even though he was signing off, he still thought

¹¹ Exhibit 35: Email re Benchmark Collisions – January 19, 2018

S/Sgt Bertram was responsible. The Niche report he approved would indicate that P/C Tamminga completed the required information but S/Sgt Sakalo testified he could not recall whether there was anything further. Sgt Gruszka also had the ability to approve tasks. S/Sgt Sakalo testified that if the officer did not put something into Niche there was nothing to approve.

S/Sgt Sakalo testified it was his experience that the T/Sgt would provide a checklist for benchmark collisions directly into the Niche system for reference of the OIC. Exhibit 40 references a Benchmark MVC Action Registry. S/Sgt Sakalo testified this was being used across the province at the time of the hearing although it was not being used in West Region at the time.

S/Sgt Sakalo outlined that on January 23, 2018, having received an email from Ms. Pharand about P/C Tamminga's investigation into the MVC involving Ms. Lucier, he placed a call on behalf of P/C Tamminga to Ms. Lucier. *"When I concluded the phone call, I sent an email to Tamminga and Cc'd [Sgt] Gruszka for his awareness."* He stated that it would not have been unusual to field complaints from members of the public. He believed that a reminder to P/C Tamminga was sufficient, stating that he had no background with this investigation. He learned later that P/C Tamminga did not call Ms. Lucier back.

S/Sgt Sakalo testified that the first time he received information about concerns regarding this file was on June 12, 2018. On that date, he received an email from court management staff Ms. Sivell, and learned that the crown brief had not been sent to court. Despite a *Promise to Appear* having been issued to the accused for March 22, 2018, no brief had been received nor had any information been sworn. The Crown Attorney asked to discuss the file including a response as to why the brief was so late.

S/Sgt Sakalo testified that following this phone call, he was at Tecumseh and he travelled to Essex to meet with P/C Tamminga to discuss the situation. He reviewed with P/C Tamminga that he was the OIC of this incident, asked if he was aware of the appropriate charges to lay and P/C Tamminga advised he was. P/C Tamminga accepted responsibility but did not provide a reasoning [for the lack of a crown brief]. S/Sgt Sakalo testified he advised P/C Tamminga that this file was his priority. He directed P/C Tamminga to meet with the court management staff and the Crown Attorney regarding this file, the following morning.

S/Sgt Sakalo was back in his position as the north Operations Manager at the time. He provided a briefing to Inspector Miller indicating the Crown Attorney may not proceed with charges. Based on the discussions with the Crown Attorney, he felt he could take action as P/C Tamminga did fall under his supervision. When Ms. Lucier called the detachment for an update, S/Sgt Sakalo again emailed P/C Tamminga for an update on the status of the brief.

S/Sgt Sakalo was asked to respond to the particulars of allegations which outlined that as P/C Tamminga's supervisor and as the responsible member for benchmark MVCs he should have been aware of the investigative delays and issues with this file. S/Sgt Sakalo reiterated that Sgt Blanchard was the supervisor for this incident and S/Sgt Bertram was the on-call staff sergeant notified of the incident. S/Sgt Sakalo testified he was responsible for benchmark MVCs but not all; he was not the responsible case manager for this specific matter.

S/Sgt Sakalo testified that he did not receive any other emails about unanswered calls to Ms. Lucier other than in June 2018. It was his testimony that if he had, "*we would likely not be here today,*" stating that he would have managed this investigation as he managed all others. He only became involved when he received an email from administrative staff in June 2018.

In relation to the allegations, the second last bullet point referenced the Crown Attorney meeting and having been advised that due to delay there was no prospect of conviction, S/Sgt Sakalo testified that they were not told that. The Crown Attorney indicated that the brief would be passed through a "*screening crown*" who would act as a consultant for P/C Tamminga.

S/Sgt Sakalo stated that he spoke to Ms. Lucier before June 28, 2018, forwarding messages to P/C Tamminga prior to that date. Ms. Lucier's decision to hire a lawyer or to contact a newspaper were not factors in his decision to forward the emails.

He disputed he was neglectful in his duties and failed to properly supervise, testifying that once he was aware of the incident, he took proper steps. S/Sgt Sakalo's notes were entered as an exhibit¹²; he testified these were his complete notes from this incident with entry dates of June 12, 2018 to July 25, 2018. S/Sgt Sakalo denied he had any supervisory or case management responsibilities in respect to this incident. Sgt Blanchard the road sergeant at the scene was the supervisor of P/C Tamminga for this case and S/Sgt Bertram was the case manager/ on-call Operations Manager.

Exhibit 31 refers to an email exchange with S/Sgt Bertram on July 5, 2018 wherein the latter officer advised it was he who was the on-call Operations Manager. Exhibit 43 is a package of email correspondence involving S/Sgt Sakalo, in relation to this matter.

Cross Examination

S/Sgt Sakalo stated that the TMU was created in the fall of 2016 and it was an idea that he had proposed. There was no sergeant in that unit as there was none available at the time of his proposal. He stated that the next ranking officer for the TMU constables would be the

¹² Exhibit 42: Package of notes – S/Sgt Sakalo

platoon sergeants to whom they were assigned. Exhibit 39 is an organizational chart dated April 3, 2017. He testified that three [of six] TMU officers followed two platoons and three followed the other two shifts. He testified that each TMU constable would have six sergeants but clarified that he would approve time off; overtime would be approved by the supervisor to whom it was directed. He agreed that he was responsible for approving vacation, completing yearly evaluations and was the assigned supervisor on Niche for the TMU members. He testified that beyond the TMU, the marine unit, mental health unit and ERT members did not have a dedicated sergeant.

He agreed he had a conversation with A/Inspector Quenneville in April 2017 about a fatal investigation and that part of the conversation was the expectation that Operations Managers were responsible for overseeing benchmark MVCs. Although he would not agree it was the case manager's responsibility to proactively manage benchmark MVCs, he testified they had to be involved in managing the case. It was his understanding the case manager was to ensure the investigation continued and it was completed whatever the outcome was. He agreed that it was the case manager's responsibility to follow up with the OIC. The goal was to have a case management meeting within a few days following a benchmark MVC.

Referencing the job description of Detachment Manager, Staff Sergeant¹³, S/Sgt Sakalo agreed this was not the job description for the north Operations Manager of Essex County. S/Sgt Sakalo agreed that his responsibility *"included other duties as assigned"*.

S/Sgt Sakalo testified that he was not intimately aware of P/C Tamminga's investigation related to Ms. Lucier's incident although he agreed that he attended a 'crown meeting' in June 2018. He agreed that sections of the file were discussed at that time. He testified he was unaware of whether there were grounds to lay either POA or criminal charges against the other driver in this matter. When questioned as to whether this was discussed at the 'crown meeting', S/Sgt Sakalo stated that he believed the file had been provided to the crown prior to the meeting but he did not see it in advance of the Crown Attorney making comments about it. He agreed that he was aware that the Crown Attorney provided an opinion that there was no reasonable prospect of conviction based on pre-charge delay. He clarified that the issue of delay would be an argument [at trial] but the opportunity to proceed with charges still existed. He agreed that because of P/C Tamminga's conduct and failure to properly process this investigation, the other driver was not charged. As a result, S/Sgt Sakalo filed an internal complaint.

S/Sgt Sakalo agreed that he received the email from Sgt Blanchard on the day of the collision as well as the email from P/C Tamminga indicating Mr. Thompson had passed away. He agreed that he received the latter email five days following his conversation with

¹³ Exhibit 41: Job Description – Detachment Manager S/Sgt

A/Inspector Quenneville about his responsibilities as a case manager. He outlined that S/Sgt Bertram however was the case manager for this matter.

He acknowledged that on April 13, 2017 T/Sgt Martin emailed him in relation to a case conference on this case and he [S/Sgt Sakalo] then asked P/C Tamminga for potential dates. S/Sgt Sakalo provided dates that he was not available as he had planned on attending the case conference. He never copied S/Sgt Bertram on the email but testified that S/Sgt Bertram should have been at the case conference as he [S/Sgt Sakalo] was there for another fatal that had occurred on April 18, 2017.

S/Sgt Sakalo agreed that he was the only Operations Manager at that meeting on May 2, 2017 but he did not stay for the full meeting due to a suicide at the detachment. He explained this was a 'two for one' meeting to address two different fatal collisions. S/Sgt Sakalo testified that he was at the meeting to support P/C Tamminga but agreed that he never followed up with him, citing he was not the on-call manager for this call. He did not clarify with T/Sgt Martin that he was not the case manager.

S/Sgt Sakalo agreed that in respect to the Niche reports he reviews and approves, very few are in relation to benchmark MVCs. In order to approve a report one needs to know about the file and he approves the reports more serious in nature. He testified that he did not assign Sgt Blanchard as supervisor at the time he approved P/C Tamminga's related Niche reports in July 2017.

S/Sgt Sakalo testified that S/Sgt Bertram had the case management responsibilities for this investigation. When S/Sgt Bertram left on an assignment in August 2017 in London, he never briefed S/Sgt Sakalo on this investigation. S/Sgt Sakalo testified he took over the role of south Operations Manager but did not take over any files, and it was without any briefing or information on outstanding tasks that he [S/Sgt Bertram] was working on.

S/Sgt Sakalo testified that S/Sgt Bertram would have remained the case manager despite working out of the London area in a new position. He disagreed that he became the case manager for this occurrence when he became the south manager. S/Sgt Sakalo disagreed that he assumed any responsibility regarding oversight of this investigation stating, "*If [S/Sgt] Bertram chose to abandon whatever work he left unfinished that was his prerogative.*"

In respect to the January 19, 2018 email from A/Inspector Quenneville^{14, 15} which included a chart, S/Sgt Sakalo could not recall but he may have added P/C Tamminga's name to the chart. He concurred at this time he would have been aware it was a fatal and it had occurred nine months prior however he stated it was assigned to S/Sgt Bertram and although

¹⁴ Exhibit 32: Email chain – Akel, Sakalo, Gruszka

¹⁵ Exhibit 35: Email re Benchmark Collisions – 19 January 2018

troubling, he was not “*diving in*” to determine why that was. After questioning related to S/Sgt Bertram no working longer in Essex County, S/Sgt Sakalo stated that S/Sgt Bertram was on-call at the time of the incident, making him the “*default case manager, whether he wanted to be or not.*” He forwarded this email on to all involved officers and their NCOs. He agreed that he did not copy S/Sgt Bertram nor Sgt Blanchard.

The following day, S/Sgt Sakalo spoke to Ms. Lucier and she expressed concerns to him about why P/C Tamminga did not respond to her and also concerns about court and charges. S/Sgt Sakalo advised that the fact that nine months had elapsed without charges meant *Highway Traffic Act* charges could not be laid and was concerning. He agreed a case manager was responsible for ensuring charges were laid.

Following his phone conversation with Ms. Lucier, he emailed P/C Tamminga to call her but he made no further inquiries. He copied Sgt Gruszka on the email but did not copy S/Sgt Bertram nor Sgt Blanchard. He copied Sgt Gruszka as he was the acting north Operations Manager and encompassed supervision of the TMU. He was sending this as an awareness to Sgt Gruszka but he had no responsibility to follow up. S/Sgt Sakalo did not recall the related response from P/C Tamminga.

S/Sgt Sakalo reiterated that there are many serious incidents in Essex County that he is not responsible for and he was not responsible for this case. He agreed that he did not copy anyone he felt was responsible on that email. He agreed that when S/Sgt Bertram returned to his position in March 2018 to September 2018, he [S/Sgt Sakalo] did not recall updating him regarding the call with Ms. Lucier. Neither S/Sgt Bertram nor Sgt Blanchard attended the ‘*crown meeting*’ in June 2018, nor were they aware of this meeting. S/Sgt Sakalo agreed that the case manager and the supervisor for this occurrence had responsibility to ensure this matter was appropriately before the courts. S/Sgt Sakalo agreed that he had operational oversight of P/C Tamminga and that prior to June 2018 he never met with P/C Tamminga to discuss charges nor provided any supervision about this occurrence.

On July 9, 2018 S/Sgt Sakalo agreed that he had a conversation with P/C Tamminga about charges and next steps. Neither Sgt Blanchard nor S/Sgt Bertram were part of this meeting. S/Sgt Sakalo provided a diary date of July 13, 2018 but his next direction was not until July 24, 2018 when he dealt with Inspector Miller and court services. He agreed that, to his knowledge, no charges had yet been laid in this case. S/Sgt Sakalo was led through the transcript of his PSB interview on September 20, 2018 wherein he was asked about following up on charges and he indicated that he had no update but had asked P/C Tamminga for an update that day [of the PSB interview].

In Examination in Chief, S/Sgt Sakalo agreed that he testified that he never mentioned to Inspector Miller that S/Sgt Bertram was the case manager as he simply wished to move the file forward, to expedite it. Inquiring what he meant by that, S/Sgt Sakalo responded he did

not think it was something Inspector Miller needed to address. He stated that he took charge of the investigation, “*actioning it*”, to take corrective measures.

S/Sgt Sakalo testified that when he returned to his position as north manager in March 2018, he was not the case manager but he began to take responsible steps to get this case before the courts “*because no-one else apparently had been.*” When suggested that between April 2017 and June 2018 that he took no steps to manage this investigation nor to supervise P/C Tamminga in respect to this investigation, S/Sgt Sakalo testified “*this was not my file to manage so I did not take any steps.*”

Examination by Ms. Lucier

Ms. Lucier questioned S/Sgt Sakalo about receiving the list from A/Inspector Quenneville after which he gave a deadline of February 19, 2018 for those responsible. He testified that some [officers] completed the work and some did not. S/Sgt Sakalo agreed he never followed up with those that did not.

S/Sgt Sakalo, when questioned why he would not have included S/Sgt Bertram and Sgt Blanchard in the email, indicated he should have done so. He clarified that the T/Sgt would not be the case manager for a benchmark MVC.

Ms. Lucier inquired why, after the phone call between them in January 2018, he did not feel compelled to bring to someone’s attention that this file was nine months old and nothing was done yet. He stated he brought it to the attention of P/C Tamminga but he did not notify Sgt Blanchard nor S/Sgt Bertram or any supervisor.

In relation to the role of T/Sgt Martin was case manager S/Sgt Sakalo clarified that he is there for oversight and support.

Referring to exhibit 37, an April 18, 2017 email from S/Sgt Sakalo about the case conference, Ms. Lucier clarified that the ‘motorcycle-turkey MVC’ happened later that same day. He testified his intent was to combine both case conferences. He stayed in the email chain as he wanted to attend for the ‘turkey’ incident.

He is not aware whether anyone else, after he approved the Niche reports related to Ms. Lucier’s incident, approved further reports. He stated that he never had any conversations with S/Sgt Bertram while he was acting south manager. He indicated that S/Sgt Bertram never advised him of outstanding items.

Re-examination

S/Sgt Sakalo, in respect to evaluations for P/C Tamminga, agreed that he was reliant on information from sergeants and he used the electronic files to reference documentation. He indicated this was due to having operational oversight versus direct supervision.

In relation to exhibit 32, the email from A/Inspector Quenneville, S/Sgt Sakalo testified that S/Sgt Bertram was also on the email. In relation to the 'motorcycle-turkey MVC', he testified he had no issues with P/C Tamminga in relation to that file.

In respect to Niche approval, while Sgt Gruszka was acting north manager, it was possible for him to review and approve P/C Tamminga's reports. S/Sgt Sakalo testified that if P/C Tamminga did not enter information on the Niche system there was nothing to approve; it is dependent on the information inputted by officers. Further, he agreed that there are no reminders regarding timelines on Niche without input from the officers.

S/Sgt Sakalo agreed that if P/C Tamminga had any concerns or was struggling with this particular investigation, it would be his expectation that P/C Tamminga would go directly to Sgt Blanchard.

When S/Sgt Sakalo moved to the south, he did not hand off any items to the acting north manager because the process is, the case manager is responsible start to finish. He agreed there is no policy deadlines for charges except legislative guidelines.

In relation to the email from A/Inspector Quenneville, email exhibit 32, 35, S/Sgt Sakalo confirmed that Sgt Gruszka was also on that email distribution list.

In relation to not notifying S/Sgt Bertram or Sgt Blanchard regarding the crown meeting and issues with this file, S/Sgt Sakalo stated when the situation was brought to his attention, he did not focus on trying to pass it off to others; he started addressing it with P/C Tamminga directly. It would have created further delays if he tried to pass it on.

PART III: SUBMISSIONS

I will outline a summary of the submissions made by each party to this hearing. It is meant as a summary only and may not capture every detail within the respective submission. Regardless, I have carefully reviewed and considered each party's position.

Summary of Defence Submissions

Defence counsel submitted that the prosecution has not proven its case. S/Sgt Sakalo testified in his defence and it was submitted that his evidence was comprehensive, clear and compelling and his actions were thorough and compassionate.

The tribunal was reminded of the seriousness of a neglect of duty charge. Defence counsel submitted that there are two parts of this charge to consider. Firstly, there must be a duty the officer was required to perform and if there was such a duty then it must be shown that

the member failed to perform the duty or the duty was not performed in a prompt and diligent manner.

Defence counsel submitted that it is possible to avoid a finding of guilt if there was a lawful excuse. The tribunal must be mindful neglect of duty requires a willfulness to the degree it crosses the line from honest mistake to neglect.

Defence counsel submitted the Notice of Hearing was premised on the false assumption that S/Sgt Sakalo was responsible for benchmark collisions in the detachment area and that he is the immediate supervisor of P/C Tamminga.

The evidence included admissions that S/Sgt Bertram was on-call on the day of the collision and it occurred in the jurisdiction over which he had responsibility. S/Sgt Sakalo was not on duty at the time of the incident and there is no reasonable expectation that he had any supervision of P/C Tamminga in this incident. It was submitted that from the evidence of S/Sgt Bertram, S/Sgt Sakalo and Sgt Gruszka, the sergeant of the day, Sgt Blanchard was responsible to ensure that P/C Tamminga brought this matter to conclusion.

In relation to the responsible case manager, defence counsel reminded the tribunal that near the end of S/Sgt Bertram's cross examination he agreed this case was his responsibility as the on-call Operations Manager. It was submitted that if one wants to transfer the responsibility it would be necessary to advise the other member. The OPP chain of command was integral, and it was P/C Tamminga, Sgt Blanchard and S/Sgt Bertram. S/Sgt Sakalo should not be found guilty of neglect of duty for a failure of the supervisors on April 9, 2017 to ask him to take carriage of this matter. There is no policy stating this is the circumstance. The evidence was that Inspector Miller would contact S/Sgt Bertram if there were questions and in cross examination S/Sgt Bertram agreed it was his responsibility.

Sgt Gruszka testified to his awareness of the process and his evidence was that unless a task was passed off by another S/Sgt then he was only responsible for matters that arose while in his tenure. It was submitted that the chain of command in April was Sgt Blanchard and S/Sgt Bertram and that remained unchanged. It was their responsibility to see this matter through to the conclusion and ensure P/C Tamminga was doing his job properly. The evidence does not support that S/Sgt Sakalo is responsible or guilty of neglect.

Summary of Prosecution Submissions

The prosecution submitted P/C Tamminga failed to move forward in this investigation and S/Sgt Sakalo shared responsibility for this, as P/C Tamminga's supervisor and case manager. The prosecution highlighted that the evidence supports a finding of neglect of duty including:

Ms. Lucier's testimony clarified her frustrations with P/C Tamminga and his failure to lay charges in this case. She shared those frustrations with S/Sgt Sakalo when they spoke on January 23, 2018 noting it had been nine months and no charges were laid. No charges will ever be laid in this case.

P/C Tamminga testified in relation to his responsibilities for this investigation and confirmed S/Sgt Sakalo was his supervisor. P/C Tamminga expressed a conflict in whether to go with careless driving or criminal charges. He admitted after October 2017, the statutory limitations precluded him from laying *Highway Traffic Act* charges. He failed to explain why he never laid *Highway Traffic Act* charges although he later laid criminal charges but failed to follow through. P/C Tamminga's evidence did not conflict with Ms. Lucier's evidence and he took responsibility for the lack of communication and incomplete investigation.

P/C Tamminga testified that he had conversations with S/Sgt Sakalo about this occurrence; he did not have any notes or specifics but he confirmed that he did not raise any issues with S/Sgt Sakalo. He did not recall S/Sgt Sakalo speaking to him about this matter between January and March 2018. He recalled later conversations in June 2018 regarding communication with Ms. Lucier. P/C Tamminga testified about the meeting with the Crown Attorney and S/Sgt Sakalo and, how ultimately it was decided there was no reasonable prospect of conviction due to pre-charge delay as a result of his actions. This established that there were errors and issues in the investigation and in reality that is the basis for the neglect of duty charge for S/Sgt Sakalo's failure to supervise this case.

A/Inspector Quenneville testified in relation to the role of case managers as well as her conversation with S/Sgt Sakalo about the enhanced responsibility with that role. S/Sgt Sakalo expressed concerns to A/Inspector Quenneville in a conversation on April 19, 2017, about this being a lot of responsibility. A/Inspector Quenneville explained how the regional team she oversaw, was more of a support service.

The prosecution reminded the tribunal of the testimony of A/S/Sgt Vanroboys and her investigation. She provided satisfactory evidence and several important exhibits were entered through her including the Niche Task Summary Report (exhibit 24) which showed S/Sgt Sakalo was P/C Tamminga's supervisor; the Niche Standard Operating Procedures (exhibit 23) which outlined the responsibilities of supervisors, as well as the audio interview of S/Sgt Sakalo wherein he admitted it was ultimately his responsibility^{16 17}.

The overview of the organizational chart of Essex County detachment showed S/Sgt Bertram as the south manager and S/Sgt Sakalo as the north manager. S/Sgt Sakalo was the only ranking officer over the TMU. It was submitted that through S/Sgt Bertram's

¹⁶ Exhibit 26: DVD-Audio of S/Sgt Sakalo interview – 20September2018

¹⁷ Exhibit 27: Transcript of above audio

testimony he did not recall any written policies in respect to on-call duties but they occurred in two-week time increments. He testified that if on-call, it was the role of the Operations Manager to provide support at the time of the incident but once the on-call was finished, the responsibilities would revert to the S/Sgt whom had supervision of the particular person noting he would “*stay in his lane.*” He did not notify S/Sgt Sakalo as Sgt Blanchard had already done so in an email.

The prosecution submitted S/Sgt Bertram testified that he transferred in July 2017 and he gave inconsistent testimony when he noted that because the collision occurred in Kingsville then Sgt Blanchard should have been supervisor and so he [S/Sgt Bertram] was the responsible case manager. It was submitted that no findings of fact could be made wherein S/Sgt Bertram contradicted himself.

The prosecution submitted the testimony of Sgt Gruszka was credible wherein he, as the acting north manager, did not have carriage of those cases which came before he took over and that evidence was not challenged. Sgt Gruszka testified about his understanding of his responsibilities as case manager for benchmark collisions; it was to ensure an investigation was thorough and complete. Those responsibilities ended once charges were laid. S/Sgt Sakalo never passed this file on to him nor discussed it with him until after the complaint was made by Ms. Lucier. Sgt Gruszka testified that the only supervisor for the TMU was the north Operations Manager.

It was submitted that Sgt Blanchard provided clear and cogent evidence about her ‘road sergeant’ duties. She testified about the steps she took on the day of the collision on April 9, 2017 but she did not supervise P/C Tamminga as he was part of the TMU. She did not supervise P/C Tamminga, she did not approve his reports, his overtime nor any activity he did. P/C Tamminga’s shifts did not always align with her platoon. This evidence was unchallenged.

Sgt Blanchard testified that she was happy when P/C Tamminga offered to investigate this collision. In relation to the case conference, although she did not have the email, Sgt Blanchard testified that S/Sgt Sakalo asked her to attend that case conference.

The prosecution submitted that portions of S/Sgt Sakalo’s evidence were self-serving, not credible and lacked cogency. His evidence about the case conference and that he was attending in respect to another MVC lacks cogency. S/Sgt Sakalo provided his availability before the other MVC even occurred and he was engaged in organizing the case conference with T/Sgt Martin. In his evidence in chief, S/Sgt Sakalo testified that he never notified Inspector Miller that S/Sgt Bertram was the case manager as he wanted to expedite this matter; the prosecution submitted this was self-serving as the evidence is that he did not expedite the matter. S/Sgt Sakalo’s explanation that S/Sgt Bertram remained the case manager in this matter lacks cogency as S/Sgt Bertram left Essex County in August 2018

and was no longer involved. It does not make sense that S/Sgt Bertram would leave and still maintain day-to-day supervision over Essex County officers.

S/Sgt Sakalo testified that he met with P/C Tamminga on July 9, 2018 and gave him a diary date of July 13, 2018 but he did not follow up on that diary date with P/C Tamminga until September 2018 at the time of his [S/Sgt Sakalo's] PSB interview.

The prosecution submitted S/Sgt Sakalo's claim that he was not the direct supervisor lacks credibility. He was the supervisor responsible for approvals of Niche reports, overtime claims and the overall management of the TMU. It was submitted that S/Sgt Sakalo's evidence was not credible in relation to his explanation that S/Sgt Bertram was the case manager and Sgt Blanchard was the direct supervisor and this is not consistent with the other evidence. S/Sgt Sakalo did not include these members in his emails in respect to this case and he never notified Sgt Blanchard in January 2018 after speaking with Ms. Lucier nor when information from the courts indicated there were issues with this case. The prosecution submitted that S/Sgt Sakalo's testimony about the reason why he did not notify S/Sgt Bertram or Sgt Blanchard was because he wanted to move the investigation along, was not a credible explanation.

The prosecution highlighted the importance of S/Sgt Sakalo copying Sgt Gruszka as the north manager and why would he do so if that position was not responsible for P/C Tamminga. S/Sgt Sakalo told PSB investigators that ultimately he was responsible for what TMU officers do or do not do. The assertion that he was responsible by virtue of him having oversight of that unit but was not the direct supervisor was not a reasonable explanation.

The prosecution provided several cases to assist in my analysis in respect to neglect of duty and the duty to supervise including *Jacobs*¹⁸, *Gottschalk*¹⁹ *Fright*²⁰, *Hewlett*²¹, *Mousseau*²² and *Neild*²³. Mr. Iafrate reminded the tribunal that the duty to supervise is the role of the case manager and is the general duty of all senior officers. This responsibility exists in all investigations, as discussed in the cases reviewed; S/Sgt Sakalo was required to move this file along to conclusion.

It was submitted that through the time period of April 9, 2017 to August 2017, S/Sgt Sakalo was the direct supervisor of P/C Tamminga and the case manager; he directly supervised the TMU and there was no sergeant in the organizational structure. P/C Tamminga testified S/Sgt Sakalo was his supervisor and S/Sgt Sakalo approved the related task on Niche.

¹⁸ Exhibit 44 –Prosecutors Book of Authorities: Tab 4: *Jacobs v Ottawa Police Service*, [2016] ONCA 345

¹⁹ Exhibit 44 - Tab 2: *Gottschalk v Toronto Police Service*, [2003] CanLii 85796 (ONCPC)

²⁰ Exhibit 44 - Tab 1: *Fright v Hamilton (Police Service)*, [2002] ONCPC 9 (CanLii)

²¹ Exhibit 44 - Tab 3: *Hewlett v Ontario Provincial Police*, [2007] ONCPC 7 (CanLii)

²² Exhibit 44 – Tab 6 : *Mousseau and the Metropolitan Toronto Police Force*, [1981] CanLii

²³ Exhibit 44 – Tab 7: *Neild v Ontario Provincial Police*, OPPHD, [15August 2016]

According to S/Sgt Sakalo's testimony, S/Sgt Bertram was responsible. At the time S/Sgt Sakalo took over the south manager position from August 2017 to March 2018, ultimately he would have been responsible and that would have included the time of the January 2018 phone call with Ms. Lucier.

The prosecution submitted the evidence of A/Inspector Quenneville supported that the case manager has oversight of the entire investigation, to make decisions, assign tasks for the officers, being involved in determining witnesses and appropriate charges; attending the meeting with the T/Sgt and to understand all aspects of the collision and to proactively guide the steps of the investigation. In West Region, only Operations Managers were case managers. This was communicated to S/Sgt Sakalo and known by S/Sgt Sakalo in April 2017.

It was submitted S/Sgt Sakalo failed in his duty to supervise P/C Tamminga in this investigation. He provided no support to P/C Tamminga until June 2018 and in the words of S/Sgt Sakalo, his failure to do so resulted in charges not being processed even though charges were in fact warranted. The prosecution submitted the evidence established that S/Sgt Sakalo was neglectful in his duty and omitted to properly and diligently perform his duty as supervisor and case manager. The evidence in this hearing covers a time period April 2017 to September 2018, beyond that outlined in the Notice of Hearing (NOH) in order to establish what responsibilities S/Sgt Sakalo had over this file, in his tenure both as north manager and as south manager.

Finally in referencing *Mancini v Courage & Niagara*²⁴, the prosecution outlined the Commission's comments that it is not necessary to prove each and every allegation contained in the statement of particulars, if the hearing officer finds one or more of the particulars are proven on clear and convincing evidence then a finding of "*discreditable conduct*" may result. The prosecution submitted these comments are applicable to a neglect of duty case. While P/C Tamminga was primarily responsible for issues with this file, the evidence provides clear and convincing evidence to support a finding of misconduct for neglect of duty for failure to supervise and case manage P/C Tamminga's investigation.

Summary of Public Complainant Submissions

Ms. Lucier submitted it is important to pay attention to the timing in this case. As early as April 13, 2017, it appeared that S/Sgt Sakalo believed he was in charge of this case by the emails with T/Sgt Martin. The emails were in relation to the case conference of which S/Sgt Sakalo stayed involved.

Ms. Lucier submitted although S/Sgt Sakalo felt he was not in charge, it was he whom T/Sgt

²⁴ Exhibit 44, Tab 5: *Mancini v Courage and Niagara Police Service*, Pg 14

Martin emailed in relation to a case conference. S/Sgt Sakalo was not the on-call manager but if S/Sgt Bertram was responsible, then S/Sgt Sakalo would have inherited the case when he transferred to act as the south manger in August 2017.

Ms. Lucier submitted that on January 23, 2018 when she spoke with S/Sgt Sakalo, she wanted answers but all she received was a promise to have P/C Tamminga call her. Further, it was shown that S/Sgt Sakalo accessed Niche and various parts of the case before calling her. She questioned why an officer of his rank would not realize that something was not right. If he had dealt with this matter in January 2018 the way he did in June 2018, this hearing would not be taking place.

Ms. Lucier submitted that she kept calling the detachment to get answers and to this day no one from Essex detachment has said there was a mistake and that there was no possibility of the driver facing charges. She questioned *“how does this happen?”*

P/C Tamminga did attend her home to advise Mr. Thompson’s brothers that careless driving would be laid. She learned of this conversation when she was released from the hospital in August 2017. She admitted that in discussions with P/C Tamminga she expressed that she was not happy that only careless driving charges would be laid but those would have been better than nothing. She submitted she learned that case was over and there would be no charges when Inspector Miller came to her home to advise her personally.

She submitted that she was told also that she could provide a Victim Impact Statement but that never occurred and when she called on January 23, 2018 she was angry, frustrated and felt she was not worthy of information; she felt invisible. P/C Tamminga continued to push her off, or ‘feed’ her lines like, *“the case is moving forward.”* She submitted that she kept calling in an effort to have someone listen to her and it took until June 2018, long past an opportunity to lay charges.

She submitted that she was deprived of justice and the possibility of resources to get on with her life and instead she is sitting in this hearing listening to everyone point fingers. S/Sgt Sakalo has even indicated T/Sgt Martin should have followed the case but the February 20, 2017 document makes it clear that the T/Sgt is a conduit between the OIC and the resources available. She submitted that S/Sgt Sakalo is blaming everyone but himself and although he may not be 100 percent to blame, he owns a piece of it as many others do.

Re-examination

Defence counsel submitted that the prosecution indicated the crown raised issues in June 2018 but that was not his recollection. It was court case management staff that raised issues with the case. It was submitted that the issue of who was the direct supervisor of P/C Tamminga was canvassed of that officer, but not specifically of other witnesses, as was

suggested by the prosecution.

Defence counsel reminded the tribunal that the conversation between A/Inspector Quenneville and S/Sgt Sakalo was not specific to the April 9, 2017 incident.

In relation to the PSB interview of S/Sgt Sakalo and the reference of ultimate responsibility, it is important to remember the context of the questioning. At page five, line 23 of the related transcript, A/S/Sgt Vanroboys asked S/Sgt Sakalo about being the direct supervisor of P/C Tamminga, S/Sgt Sakalo indicated “yes and no”, he had operational oversight of TMU whose members are independent workers however the members get direction not supervision. Defence counsel submitted that the practical reality was such that working an administrative schedule, it is physically not possible for S/Sgt Sakalo to have direct supervision of the individuals in that unit.

The absence of discussions between S/Sgt Sakalo and Sgt Gruszka in his acting capacity in relation to any ‘hand off’ is not evidence. The reason why no such conversation took place is because S/Sgt Sakalo was of the firm belief that S/Sgt Bertram was the responsible manager. The chain of command on April 9, 2017 was P/C Tamminga, Sgt Blanchard and S/Sgt Bertram and that never changed. S/Sgt Sakalo should not be found guilty because he became involved in a cursory manner when he was not the supervisor responsible in relation to this incident. In fact, following their arguments, S/Sgt Sakalo would have been in a stronger position had he done nothing and that would have been equally unacceptable.

In relation to the May 2, 2017 case conference S/Sgt Sakalo was advancing the logistics for that meeting and that was his only intention. In relation to the prosecution submission challenging the credibility of S/Sgt Sakalo’s testimony concerning the case conference and that he only attended for purposes of the MVC involving the turkey, defence counsel submitted there is no evidence to challenge this. Defence counsel submitted if the prosecution had these concerns then questions could have been put to P/C Tamminga. Defence further suggested the prosecution could have asked PSB to investigate whether such an accident existed. It was submitted neither of those enquiries took place and this should be disregarded altogether.

In addressing the case law presented, defence counsel referred to the passage in *Fright* that supervisors must supervise and “*the buck stops*” there, and submitted the “*buck stops*” with Sgt Blanchard and S/Sgt Bertram. In respect to the Commission’s comments in *Hewlett*, defence counsel submitted similarly that Sgt Blanchard “*was not a passive bystander... was responsible to ensure... officers under [her] supervision perform their duties as assigned.*” She assigned P/C Tamminga and, as in *Hewitt*, it was her role to provide advice and guidance.

In commenting on *Mancini*, defence counsel reminded the tribunal that it would be wrong in

law to consider any evidence outside of the parameters in the NOH.

In respect to *Neild*, defence counsel submitted that one could substitute the name Sgt Blanchard for Sgt Neild. Defence counsel submitted as in *Neild*, Sgt Blanchard “*had the ultimate responsibility to perform a duty and that was to supervise the death investigation...This included giving direction to [her] officersto take all necessary steps to secure the scene, preserve and collect evidence...*”

It was submitted that the prosecution stated S/Sgt Sakalo did not support P/C Tamminga. The chain of command did not involve S/Sgt Sakalo and P/C Tamminga did not seek assistance from anyone.

In relation to the submissions of Ms. Lucier, defence counsel reminded the tribunal that this process is not about justice but assessing the conduct of S/Sgt Sakalo. S/Sgt Sakalo performed as was expected in his capacity but not in the capacity of those responsible. It is not a reflection of not accepting responsibility but a reflection on the reality of the process that exists.

PART IV: ANALYSIS AND FINDINGS

Analysis

I concur with defence counsel who submitted that neglect of duty is a very serious charge. I find it is important to consider the Commission’s comments in *Gottschalk v. Toronto Police Service*, 2003 CanLII 85796 (ONCPC) of what constitutes neglect of duty:

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

The member was required to perform a duty, and the member failed to perform this duty because of neglect, or did not perform the duty in a prompt and diligent manner. Once proven, the member, to avoid discipline, must show that:

[The member] had a lawful excuse for not performing the duty in the prescribed manner.

...It is not an absolute offence...there must be either “wilfulness” or a degree of neglect which would make the matter cross the line from a mere performance consideration to a matter of misconduct”.

Throughout my analysis I have considered the credibility and reliability of the witnesses in this hearing. For each witness I have considered whether the evidence given, was in

“harmony with the preponderance of probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions.”²⁵

Issues Identified

In determining whether S/Sgt Sakalo’s conduct meets the threshold of misconduct I have identified the following issues to be addressed:

- Was S/Sgt Sakalo required to perform a duty?
- If he had a duty, did S/Sgt Sakalo neglect to perform the duty or did he not perform the duty in a prompt and diligent manner.
- If S/Sgt Sakalo’s conduct does meet the threshold of neglect of duty, is there a lawful excuse?
- Does the neglect amount to misconduct or it is a mere performance issue?
- Does the totality of the evidence presented at the hearing meet the threshold of clear and convincing?

Timeline

In order to assist my analysis, the following is a timeline set out through uncontested evidence, largely through emails submitted as documentary evidence. I will address how any of the outlined documents factor in my *“Analysis”* section.

April 3, 2017 - According to an organizational chart, S/Sgt Sakalo had responsibility for oversight of the TMU.

April 9, 2017 – Email from Sgt Blanchard regarding the MVC involving Ms. Lucier, sent to Inspector Miller, S/Sgt Bertram, S/Sgt Sakalo, S/Sgt Beatty, S/Sgt Marocko, P/C Jim Root, Sgt Shawn Diewold, P/C Tamminga.²⁶

An undated Technical Collision / Reconstruction 24 hr Notification Report²⁷ by Rich Bortolon (the involved TTCI officer) listed the investigating officer of the collision as P/C Tamminga and the supervising NCO as Sgt Tracy Blanchard.

April 11, 2017 - Email chain from April 9, 2017 continued, with an update from P/C Tamminga to all those names noted above and additionally Rich Bortolon.

²⁵ *Faryna v. Chorny* (1951) B.C.J. No 151 (BCCA)

²⁶ Exhibit 17: Email starts with Tracy Blanchard, ends Stuart Bertram – 09April2017

²⁷ Exhibit 38: Technical Collision / Reconstructionist Report

April 13, 2017 - Email chain from April 9, 2017 continued, with T/Sgt Martin addressing S/Sgt Sakalo only. T/Sgt Martin noted awareness that S/Sgt Sakalo was on block [training] but to advise him when there are plans for a case conference and he would attend. S/Sgt Sakalo responded immediately, 'looping in' P/C Tamminga and asking him to identify a date for a case conference.

April 18, 2017 - P/C Tamminga replied to the email chain above and suggested April 27, 2017 for a case conference. T/Sgt Martin was available but S/Sgt Sakalo noted there was a scheduled meeting and neither he nor Sgt Blanchard would be able to attend. T/Sgt Martin advised he was off [April] 28 but could attend if needed.

April 21, 2017 – Mr. Paul Thompson succumbed to his injuries.

April 24, 2017 1125 am - Email²⁸ from P/C Tamminga to Inspector Miller, S/Sgt Sakalo, Sgt Blanchard, Sgt Root, T/Sgt Martin and A/Inspector Quenneville advising that he confirmed Mr. Thompson had died as a result of his injuries. He noted he would update Electronic Collision Reporting System (ECRS) and Niche.

May 2, 2017 – Case conference meeting regarding benchmark MVC involving Ms. Lucier.

August 2017 – S/Sgt Sakalo took over duties as the south Operations Manager and Sgt Gruszka took over as the acting north Operations Manager.

January 19, 2018 – A/Inspector Quenneville sent an email²⁹ which included a chart outlining 2017 benchmark collisions that required either administrative or investigative follow-up. This email was sent to all detachment S/Sgts, including S/Sgt Sakalo and S/Sgt Bertram.

January 22, 2018 - S/Sgt Sakalo forwarded the above message to those officers whose names were noted on the chart including to P/C Tamminga in relation to LP17096588 (MVC involving Ms. Lucier).

January 23, 2018 – S/Sgt Sakalo had a telephone conversation with Ms. Lucier wherein she related concerns about the case. S/Sgt Sakalo emailed P/C Tamminga to contact Ms. Lucier.

March 2018 – S/Sgt Sakalo returned to his position as the north Operations Manager (according to his testimony).

²⁸ Exhibit 37: Email 09April2017 – 24April2017

²⁹ Exhibit 32: Email chain – Akel, Sakalo, Gruszka

June 12, 2018 2:31 pm - Email from Ms. Wendy Sivell (court-case management) to S/Sgt Sakalo. There was no reference to this case but it indicated that she was dealing with a situation that would require his attention. There was a response by S/Sgt Sakalo to Ms. Sivell with a copy to S/Sgt Marocko indicating, *“Brief not done. Rene will be joining you to speak with Belinda tomorrow morning to provide an explanation for this situation.”*

June 13, 2018, 7:23 am - Email from Ms. Sivell to S/Sgt Sakalo thanking him for his immediate action. In his response a couple minutes later, S/Sgt noted, *“If there is any explanation needed...then I would prefer Rene provide it. He is the one who is ultimately responsible for the lack of work on this file and should be the one to explain why it isn’t completed.”*

June 13, 2018, 10:06 am - Following an email from Ms. Sivell requesting a time and phone number to contact S/Sgt Sakalo, the following email from S/Sgt Sakalo was sent to S/Sgt Marocko and Inspector Miller with a copy to S/Sgt Bertram advising the update from Ms. Sivell and the instructions from the crown’s office.

June 13, 2018, 10:12 am - Email from S/Sgt Sakalo to P/C Tamminga with a copy to S/Sgt Marocko and Inspector Miller requesting P/C Tamminga complete the crown brief with all statements and evidence on the crown’s desk as soon as possible and a meeting with the crown is being arranged. He advised P/C Tamminga to be prepared to explain why the file had not been completed.

June 13, 2018 , 10:37 am - Email from Ms. Sivell to P/C Tamminga with a copy to S/Sgt Sakalo indicating discussions with the deputy crown with three points to complete and indicating P/C Tamminga and S/Sgt Sakalo were to meet with her [the crown] the following week to discuss the file.

June 18, 2018, 11:35 am – An email from S/Sgt Sakalo to P/C Tamminga *“Is the fatal brief completed?”*

June 18, 2018, 1:04 pm -An email from Ms. Pharand to P/C Tamminga with a copy to S/Sgt Sakalo, *“urgent phone message – Rene, Please return the message as soon as possible. Mrs. Dorothy Lucier [ph #]”*

June 18, 2018 2:15 pm - P/C Tamminga responded to S/Sgt Sakalo’s inquiry about the brief and noted that it was *“pretty well done”* and he would be in the following night and finish it then. S/Sgt Sakalo forwarded this email to Inspector Miller noting he could not understand how *“this has been dragging on.”*

June 18, 2018 3:27 pm - Email from S/Sgt Sakalo to P/C Tamminga inquiring, *“Have you called Mrs. Lucier yet?”*

June 18, 2018 4:09 pm - Email from P/C Tamminga to Ms. Pharand with a copy to S/Sgt Sakalo *"Hi Lise, I reached out to her earlier. I will call her."*

June 19, 20, 2018 - Emails between S/Sgt Sakalo and Ms. Sivell in relation to a meeting with the Crown Attorney set for June 21, 2018. In relation to an inquiry about whether P/C Tamminga was required at the meeting, Ms. Sivell quoted the crown as *"either both of them attend or just his boss, that is up to them."*

June 20, 2018, 7:51 am - Email from S/Sgt Sakalo to P/C Tamminga regarding a meeting with the Crown Attorney the following day. P/C Tamminga responded at 2:18 pm that he had court in Leamington. S/Sgt Sakalo inquired if it was criminal or traffic court. Upon reply S/Sgt Sakalo noted the Leamington court matter would be adjourned.

June 20, 2018 10:42 am to 12:43 pm - An email³⁰ exchange between S/Sgt Sakalo and Ms. Lori Myers regarding a call from Ms. Lucier's lawyer requesting a conference call with P/C Tamminga's supervisor *"They are requesting the conference call be set at your earliest convenience..."* In the same email chain were S/Sgt Sakalo's comments to Inspector Miller about not understanding how this case had been dragging on.

June 20, 2018 11:58 am – Email response to Ms. Myers from S/Sgt Sakalo wherein he indicated, *"Given the circumstances of this incident...the OPP will not be discussing this case outside of court proceedings."*

June 21, 2018 - S/Sgt Sakalo drafted an Information Note regarding *"incomplete criminal investigation (fatal collision) by P/C Tamminga"*. It noted, *"P/C Tamminga was the investigating officer assisted by members of D platoon supervised by Sgt Blanchard."* It was noted the Crown Attorney had concerns in relation to the significant pre-charge delay. P/C Tamminga took responsibility for it but did not provide an explanation as to why. The notation under next steps was *"Await the Pre-charge review report from the assigned screening Crown."*

June 21, 2018 - Meeting with P/C Tamminga, S/Sgt Sakalo and the Deputy Crown Attorney to discuss next steps.

June 22, 2018 - Email from S/Sgt Sakalo to Inspector Miller³¹ with Information Note attached, *"as requested."*

June 25, 2018 10:01 am - Email from Ms. Pharand to S/Sgt Sakalo noting, *"I have two more messages on my answering machine from Denise Lucier [phone #]. Her exact words were*

³⁰ Exhibit 43: Package of emails involving S/Sgt Sakalo and this incident

³¹ Exhibit 43 Package of emails involving S/Sgt Sakalo and this incident

'I want to know when officer Tamminga will return my call?' I don't know what to do with this poor lady." S/Sgt Sakalo forwarded this email to P/C Tamminga and Ms. Pharand and instructed P/C Tamminga to call Ms. Lucier that day. He indicated that he had understood that P/C Tamminga had called Ms. Lucier the previous week.

June 26, 2018 at 9:54 am - Email from S/Sgt Sakalo to P/C Tamminga asking if he had contacted Ms. Lucier yet and that her lawyer had been calling the detachment daily.

June 26, 2018 at 5:21 pm - Email from P/C Tamminga responding to S/Sgt Sakalo that he had reached out to [Ms. Lucier] last week as promised. He provided her his contact information and offered to meet with her once there was some indication from the Crown Attorney's office.

June 28, 2018 at 11:59 am - Email from Ms. Pharand to S/Sgt Sakalo indicating Ms. Lucier called again and was still waiting for a return call. S/Sgt Sakalo forwarded the email to P/C Tamminga and noted he was not sure where the "disconnect" was but to call Ms. Lucier as soon as possible.

June 28, 2018 6:08 pm - Email from S/Sgt Sakalo to Inspector Miller, titled "From Rene" the body of the email read,

*"I was finally able to speak with her Brad
I am and have been committed to assisting her
I have provided her what I could without making promises
I could not keep I will reach out to her tomorrow again"*

June 29, 2018 8:49 am - Email to Inspector Miller with a copy to Ms. Pharand. It referenced an updated information note and an LE27 (internal complaint) was to follow.

July 2, 2018 4:11 pm - Email from S/Sgt Sakalo to Inspector Miller with LE27, Information note attached, *"as requested."*

July 4, 2018 8:17 am - Email from Inspector Miller to A/Sgt Major Dan Rowbotham, A/Sgt Stephen Cole with a copy to Ms. Pharand, S/Sgt Marocko including the internal complaint on P/C Tamminga for their review and furtherance.

July 5, 2018 10:25 am - Email from the Crown Attorney's office to S/Sgt Sakalo indicating that given the information supplied, the evidence *"likely made out the offence of dangerous driving beyond a reasonable doubt at the time of the investigation or soon thereafter. However due to pre-charge delay there no longer exists a reasonable prospect of conviction."*

The above email was forwarded by S/Sgt Sakalo to P/C Tamminga with a copy to Inspector Miller and indicated he [S/Sgt Sakalo] was available for a conversation if necessary.

July 5, 2020 11:20 am - Email from Inspector Miller to S/Sgt Sakalo with copy to Ms. Pharand and S/Sgt Bertram response to the above email indicating to include the information from the Crown Attorney's office in the Information Note and the Complaint Intake Form (Le027). Further, he indicated that *"we need to incorporate our supervisory oversight on this particular file in accordance with the Directive that is aligned with RHQ policy on Fatal Collisions."*

July 5, 2018 - Emails between S/Sgts Sakalo and Bertam related to who was on call at the time of this fatal collision. It would appear that S/Sgt Bertram was on call and S/Sgt Sakalo was on block training at the time. Neither had any notes on the call although both referenced the email sent by Sgt Blanchard the night of the collision.

July 6, 2018 - Emails between S/Sgt Sakalo and Sgt Blanchard regarding notification to command of the collision. Sgt Blanchard noted that it was not immediately a fatal and that she believed that he (S/Sgt Sakalo) scheduled a meeting for those involved and he was around but it was a *"bit hectic because it was near the time P/C Bilodeau's passing."*

July 9, 2018 - Email from S/Sgt Sakalo to P/C Tamminga inquiring how he was proceeding with charges now that he had the information from the Crown Attorney. On the same day, an email from S/Sgt Sakalo to Inspector Miller and S/Sgt Marocko indicated P/C Tamminga had decided to lay charges and *"has been directed to move forward on this file this week and advise."* Further, he noted that a consultation meeting was scheduled but never held, in part due to the death of a detachment officer.

July 9, 2018 3:47 pm - Email from A/Sgt Rowbotham (PSB) to Inspector Miller, D/Sgt Cole (PSB), S/Sgt Marocko and Ms. Pharand indicating the file had been reviewed and the supervisor for P/C Tamminga is requested to be identified and the complaint form updated accordingly.

July 10, 2018 - Email was sent from S/Sgt Marocko to S/Sgt Sakalo asking him to update the Complaint Intake form with the information identifying P/C Tamminga's supervisor.

July 24, 2018 - Email from PSB personnel to Inspector Miller with the title *"Notification of Internal Complaint"*.

September 20, 2018 - S/Sgt Sakalo was interviewed by PSB investigators in relation to this investigation.

Was S/Sgt Sakalo required to perform a duty?

Before determining whether S/Sgt Sakalo was required to perform a duty, I must first identify P/C Tamminga's supervisor and the responsible case manager for the benchmark collision involving Ms. Lucier. Defence counsel submitted that it was fair to say the lines of responsibility and lines of communication were not clear in this situation. While the lines of communication could have been better, I have analyzed the evidence of each witness and determined the responsible supervisor and case manager for this file.

In respect to issues of supervision and case management, the evidence of S/Sgt Sakalo contradicted the evidence of other witnesses as did S/Sgt Bertram's evidence although the latter's evidence can only be described as inconsistent. I acknowledge that in cross examination S/Sgt Bertram agreed this matter was his to case to manage. I concur with the prosecution that in relation to S/Sgt Bertram's understanding of the responsible supervisor/case manager, I will not be able to rely on that evidence for any findings of fact. Although I accepted certain portions of S/Sgt Sakalo's evidence, in addressing the issues of supervision and case management, I found the evidence of other witnesses more reliable. I will outline my reasons for that further on in my analysis.

Gottschalk, Hewlett, Fright and Neild all highlight that a supervisor has a duty to supervise and that includes to ensure the OIC takes the appropriate steps in an investigation. I have discussed those cases further on in this analysis. This case deals with direct supervision as well as the enhanced responsibilities of the role of case manager.

P/C Tamminga testified that S/Sgt Sakalo was his supervisor. S/Sgt Sakalo was listed as P/C Tamminga's supervisor on Niche and it was he who approved the occurrence report submitted by P/C Tamminga in relation to the MVC in question.

I have considered the testimony of S/Sgt Sakalo. He testified that it was his idea to create the TMU and there was no sergeant in the reporting structure of that unit. As there was no sergeant position available to assign to the TMU, it was his assertion before the tribunal that the next ranking member to the constables in the TMU was the platoon sergeant on shift. He testified that there were six members in the TMU and they received supervision from the sergeants on the four platoons in Essex County. They were grouped with three officers assigned to each half of the detachment platoon strength. Exhibit 36 outlines S/Sgt Sakalo is responsible for supervision of: Lakeshore, Tecumseh, Marine Unit, Traffic Program and Provincial.

S/Sgt Sakalo completed evaluations and approved vacation for the TMU members but he stated that overtime would be approved by the particular sergeant who authorized the overtime. He was the dedicated supervisor for P/C Tamminga on Niche. S/Sgt Sakalo testified that if the TMU officers had any issues with the platoon sergeants they would come

to him. An email from T/Sgt Martin to S/Sgt Sakalo on April 13, 2017 inquiring about the date of the case conference meeting indicates that T/Sgt Martin was of the belief that S/Sgt Sakalo was either the supervisor of the OIC [P/C Tamminga] or the case manager, or both.

Exhibit 43 contains a number of emails one dated June 20, 2018 from Ms. Myers (OPP) notifying S/Sgt Sakalo that Ms. Lucier's lawyers are requesting a call with P/C Tamminga's supervisor and asking for his [S/Sgt Sakalo's] availability for the call. Another email from that same day from Ms. Sivell (OPP court management) requested that either, both P/C Tamminga and "*his boss*", or "*just his boss*" attend the meeting with the Crown Attorney.

I am not swayed by S/Sgt Sakalo's testimony that he took on this meeting and related actions without notifying others that he deemed were actually responsible, in order to move the file forward. These messages support the proposition that S/Sgt Sakalo was the responsible supervisor for P/C Tamminga. In his April 13, 2017 email with T/Sgt Martin regarding the case conference, S/Sgt Sakalo 'loops in' P/C Tamminga but not S/Sgt Bertram. This is indicative and would infer that if he is the direct supervisor to P/C Tamminga, it would be redundant to involve a second Operations Manager to serve as the case manager.

I do not find S/Sgt Sakalo's evidence credible that when he approved the related Niche report in July 2017, he believed it was S/Sgt Bertram's file to manage. S/Sgt Sakalo did not assign a task to either Sgt Blanchard or S/Sgt Bertram at that time. There is no evidence from emails of April 13, 2017 onwards up to the point this became a formal complaint, that S/Sgt Sakalo involved or notified any other supervisor or case manager in relation to this file.

I acknowledge defence counsel submissions that S/Sgt Bertram, T/Sgt Martin, and Sgt Blanchard all had more involvement in this matter than S/Sgt Sakalo did. I agree, in relation to the scene of this benchmark MVC that is the case but that does not necessarily include ongoing responsibilities of supervision and oversight.

Sgt Blanchard provided clear and credible evidence as to why she was not P/C Tamminga's supervisor for this incident. She did not approve vacation, Niche reports nor overtime for P/C Tamminga. It does not make sense that TMU members would have multiple supervisors as suggested by S/Sgt Sakalo. Certainly, as the ranking officer on a shift, a sergeant could be deemed to be supervising a member that was not on their particular shift but there is always one primary supervisor to whom a member reports. Sgt Blanchard, by all accounts including the statements of S/Sgt Bertram in his PSB interview, was a very competent supervisor.

I found the testimony of Sgt Gruszka fair and compelling. He outlined that the platoon sergeant was the supervisor for a benchmark MVC, at the time of the incident. It would then

fall to the direct supervisor of the member identified as the OIC. In this case, this was the north Operations Manager.

I accept the testimony of A/Inspector Quenneville who outlined that ultimately the Operations Managers at detachment are responsible for benchmark collisions. She was in charge of the traffic program and the West Region Command staff directed that the Operations Managers would be the case managers. Case managers have oversight of the entire investigation including speed, direction and flow. Case managers must make decisions and assign tasks for the OIC including determining witnesses and ensuring the appropriate charges are laid. Further, she testified that she had been advised by the Regional Traffic Manager Inspector Lisa Anderson as well as West Region Command staff that this expectation had been communicated.

Although the conversation was not in relation to the matter at hand, A/Inspector Quenneville outlined a general conversation she had with S/Sgt Sakalo on April 19, 2017 and his concerns about the significant responsibilities in his role as case manager. She testified that after the initial case conference, it was left to the Operations Manager to have oversight of the investigation which would include having contact with those officers that were assigned as the 'lead' or 'file'.

S/Sgt Sakalo was involved in organizing a case conference for this matter. Given the second benchmark MVC involving a motorcycle and a turkey occurred after he sent the April 18, 2017 case conference email, I find S/Sgt Sakalo's explanation that it was his intention to attend as case manager only for the investigation involving the turkey and not the Lucier MVC, not credible. It makes no sense in terms of timing of the email and it contradicts with the preponderance of evidence. S/Sgt Sakalo engaged in organizing the Lucier MVC case conference without asking for the input of other supervisors or S/Sgt Bertram. S/Sgt Sakalo's evidence was that he did not know why S/Sgt Bertram was not at the case conference when he should have been. The reason would have to have been clear to S/Sgt Sakalo as he did not include/invite S/Sgt Bertram on the email chain while the case conference was being arranged. S/Sgt Sakalo did not advise T/Sgt Martin that S/Sgt Bertram was the responsible case manager.

I do not find S/Sgt Sakalo's explanation as to why issues with this case were not brought to the attention of those he believed to be the responsible supervisor and case manager, as credible. In January 2018, upon receiving the list of benchmark collisions requiring attention, he did not copy Sgt Blanchard nor did he engage in clarification with S/Sgt Bertram to confirm he [S/Sgt Bertram] was still the case manager despite that S/Sgt Bertram no longer worked in Essex County. S/Sgt Sakalo was the acting south Operations Manager at that time.

S/Sgt Sakalo returned a phone call to Ms. Lucier on January 23, 2018, after she had called wishing to speak to P/C Tamminga's supervisor. Neither S/Sgt Bertram nor Sgt Blanchard were ever notified of this call nor more importantly of Ms. Lucier's concerns. I acknowledge that Sgt Gruszka was on that same email distribution list regarding the benchmark collision updates and was copied on the email about the call to Ms. Lucier on January 23, 2018. Sgt Gruszka was acting north manager at the time, but there is no credible evidence to support that Sgt Gruszka was responsible as either the supervisor or case manager of this file. S/Sgt Sakalo confirmed this in his testimony.

Finding:

I find the evidence is clear that S/Sgt Sakalo was the direct supervisor over P/C Tamminga at the time of this incident. P/C Tamminga was in a specialized unit and his reporting relationship was directly to S/Sgt Sakalo. S/Sgt Sakalo was also a case manager for benchmark MVCs and this brought about an enhanced responsibility of oversight and guidance for such collisions.

I find although there was no sergeant position between S/Sgt Sakalo and P/C Tamminga, he had a duty to supervise P/C Tamminga. This finding is supported by the Niche information and the Niche Standard Operating Procedure Manual. S/Sgt Sakalo was listed as the P/C Tamminga's supervisor and he approved the Niche reports directly related to this benchmark MVC. S/Sgt Sakalo did not assign a task to another supervisor to follow up on this investigation to oversee P/C Tamminga. He could well have done that and assigned Sgt Blanchard to oversee this investigation. That action may also have resulted in a different outcome. As P/C Tamminga's supervisor, S/Sgt Sakalo was required to ensure this file progressed to a conclusion within the time parameters that existed for *Provincial Offences Act* and *Criminal Code* related charges.

Further, S/Sgt Sakalo holds the general duty of all senior officers to supervise those holding *lesser* ranks. I agree that at the time of the incident S/Sgt Sakalo was not the on-call Operations Manager and he was in block training the following week. S/Sgt Sakalo however held the role of an Operations / Case Manager and had expertise and experience in that role. Regardless of who was on-call on the night of the incident, S/Sgt Sakalo was responsible for approving the related Niche report. He was the supervisor who had knowledge of P/C Tamminga's investigative efforts and reporting.

I have considered the comments of defence counsel that one cannot impugn S/Sgt Sakalo because of actions he took in June 2018, as the chain of command in this matter led to S/Sgt Bertram. I acknowledge the testimony of S/Sgt Bertram wherein he admitted he was the responsible case manager. I have considered possible systemic issues and whether and when a 'hand off' of the case management responsibilities occurred. I can agree for days following the April 9, 2017 MVC, S/Sgt Bertram was the responsible case manager. I have considered defence counsel submissions that Niche report approval and the May 2, 2017

case conference meeting do not equate to responsibility. However, beginning April 13, 2017, email correspondence related to setting up a case conference for this matter supports that S/Sgt Sakalo was aware and accepted that he was the responsible case manager. He did not engage nor invite S/Sgt Bertram in the case conference emails. When Mr. Thompson died as a result of his injuries on April 21, 2017, P/C Tamminga sent an update to a number of people, notably not S/Sgt Bertram. Through emails and his actions in relation to the case conference, I find S/Sgt Sakalo took on the role of case manager for this file.

Was S/Sgt Sakalo neglectful in his duty to supervise or did he fail to promptly and diligently perform the duty?

I have considered *Gottschalk v Toronto Police Service*³² which outlines the standard in respect to allegations of neglect of duty including:

It is also worth noting that neglect of duty is not an absolute offence. The law is clear that there must be either “willfulness” or “a degree of neglect which would make the matter cross the line from a mere performance consideration to a matter of misconduct.

There is no doubt senior police officials have a duty to properly supervise subordinate officers and those under their command. This would include an obligation to follow up on allegations of potential serious misconduct or dereliction of duty. This is a responsibility that is both implicit in the nature of command and found at Toronto Police Service Rule 3.5.1.

*Fright v Hamilton (Police Service)*³³ supports the expectation that supervisors must supervise. This is particularly important when those under their supervision fail to complete thorough and professional investigations. The Commission in *Fright* highlighted this expectation:

The Appellant urges us to find that the only individuals responsible to ensure that the reports are filed were the officers who attended the scene. We cannot accept that proposition. Supervisors must supervise. The buck stops there. We find that there is a clear and unequivocal policy in place with respect to this issue. Supervisors have a duty to ensure that complete signed reports are filed. This did not occur.

The Commission in *Hewlett v OPP* highlighted that the responsibilities of a supervisor cannot be discarded or ignored and that Sgt Hewlett as a supervisor was:

³² Exhibit 44 – Tab 2: *Gottschalk v Toronto Police Service*, [29Jan2003] OCPC para 55, 56

³³ Exhibit 44 – Tab 1: *Fright v Hamilton (Police Service)*, [2002] ONCPC 9, pg6 para 3-4

Responsible to ensure that the officers under his supervision satisfactorily perform their duties as assigned. This is self-evident and does not require a specific policy or procedure.

[His] role was to provide advice and guidance while the occurrence was being investigated; afterwards, his role was to ensure that the investigation was properly completed by his officers.

Neild v OPP supports the proposition of the duty of a supervisor to supervise. While the OIC is ultimately responsible for the investigation it is the ongoing duty of a supervisor to ensure the OIC takes the appropriate steps.

I have reviewed and noted the information contained in the Niche Records Management System (RMS) Standard Operating Procedure Manual³⁴ which outlines the following in respect to the responsibilities of supervisors:

Supervisor

A supervisor or delegated member shall be responsible for ensuring all occurrences are reviewed, and the appropriate task status selected.

A supervisor or delegated member upon reviewing occurrences shall:

- check for accuracy, completeness and minimum data requirements;*
- ensure all mandatory notifications have been made;*
- ensure no further action or report is required;*
- ensure UCR incident is complete and accurate;*
- ensure all information is added to the database and linked accurately; and*
- create and send a task to a member, if necessary.*

A supervisor or delegated member shall ensure all detachment members are informed on matters of detachment concern prior to commencement of patrol. The Niche RMS BOLO (Be On the Look Out) list should be reviewed by members at the commencement of a shift in order to comply with the preceding direction

SPECIALIZED UNITS

PERSONNEL

Introduction *Employees of an OPP specialized unit who have authorized access to the Niche RMS shall be responsible for maintaining the integrity and quality of the information on the Niche RMS.*

³⁴ Exhibit 23: Niche RMS SOP manual

RESPONSIBILITIES

Supervisor

When an occurrence is generated within a specialized unit, the supervisor or member-in-charge shall comply with the criteria outlined in the section under Personnel—Responsibilities—Supervisor.

A supervisor or member-in-charge is responsible for the management of any tasks created for that unit.

The cases and policies outlined above provide me guidance. Witness testimony highlighted conflicting evidence about responsibilities and reporting relationships. Sgt Blanchard was identified by both S/Sgt Sakalo and S/Sgt Bertram (in his testimony) as having responsibility for oversight of the ongoing MVC investigation involving Ms. Lucier. I do not find this to be the case. I have considered defence counsel submissions suggesting Sgt Blanchard's duties were as outlined in *Neild*. I concur Sgt Blanchard had duties as a supervisor at the MVC scene involving Ms. Lucier. Unlike in *Neild*, there is no evidence that supports her supervision was lacking at that scene. She was the scene supervisor on the night of the collision but that does not make her P/C Tamminga's supervisor nor does it make her responsible for P/C Tamminga's failure to complete this investigation to a conclusion. I find exhibit 38, the Technical Collision / Reconstruction 24 hr Notification Report which listed Sgt Blanchard as the supervising NCO is only in relation to the accident scene, as the other details in that section also relate.

I found Sgt Blanchard's testimony clear and compelling and according to S/Sgt Bertram in his PSB interview, she was a very competent sergeant and was very thorough in her notification and scene management. I find her testimony credible and agree that she did her role, managed the scene of the collision and completed her responsibilities for that scene.

Undoubtedly Sgt Blanchard, because of her role at the scene, would have been an important participant at the case conference. However, Sgt Blanchard did not approve the related Niche reports completed by P/C Tamminga, nor did she receive the January 19, 2018 email³⁵ from A/Inspector Quenneville that was sent on to detachment S/Sgts, including S/Sgt Sakalo and S/Sgt Bertram or from S/Sgt Sakalo which included a chart outlining '2017 Benchmark Collisions' that required either administrative or investigative follow-up.

P/C Tamminga was a member of the TMU and S/Sgt Sakalo was the 'member in charge' of that specialty unit and his responsibilities included ensuring the occurrence was reviewed and the appropriate task status selected. Further, the relevant responsibilities for this matter included to check for accuracy, completeness and ensure no further action or report was

³⁵ Exhibit 32: Email chain – Akel, Sakalo, Gruszka

required and to create and send a task to a member if necessary. Regardless of whether P/C Tamminga had added a task or marked it completed, S/Sgt Sakalo as the supervisor would have the ability to review P/C Tamminga's reports and if necessary, add a task with a diary date. This was a necessary action and then it would have required S/Sgt Sakalo to follow up with the task at or before the noted diary date. At the time of the Niche report approval, S/Sgt Sakalo would have been unlikely to identify P/C Tamminga's inability to move forward with this case. S/Sgt Sakalo however was responsible for ensuring the information in Niche was accurate and the investigation was moving forward.

S/Sgt Sakalo approved the general occurrence report on July 4, 2017. At that time, S/Sgt Sakalo would have been aware that Mr. Thompson died as a result of injuries sustained in this benchmark MVC. Further, this knowledge should have heightened S/Sgt Sakalo's awareness of the seriousness of this investigation. A man lost his life and Ms. Lucier lost a limb and her partner. It does not get much more serious than that and this case deserved to be prioritized. As S/Sgt Sakalo expressed to A/Inspector Quenneville, the role of case manager was a lot of responsibility. I agree but that was S/Sgt Sakalo's role.

S/Sgt Sakalo was presented with several other opportunities. In January 2018, S/Sgt Sakalo received a 'Benchmark Collision Review 2017' list of investigations that required follow-up. The chart was sent from A/Inspector Quenneville to S/Sgts in Essex County. The chart listed the date of the incident, whether it was a fatal and follow up required. P/C Tamminga's name was on that list and it outlined that the report noted the driver was charged but *"Update needed"*. Knowing P/C Tamminga's name was on the list and knowing the date the incident occurred, regardless of changes in roles, was another opportunity for S/Sgt Sakalo to recognize this investigation needed supervision and case management.

On January 22, 2019 S/Sgt Sakalo forwarded the above-noted message to those officers whose names were noted on this chart including to P/C Tamminga in relation to LP17096588, the MVC involving Ms. Lucier. S/Sgt Sakalo's instructions were to *"advise your NCO when completed. NCO report backs due Feb 19."* P/C Akel was also on the list and he responded to S/Sgt Sakalo with a copy to Sgt Gruszka indicating what he had added to the supplementary report on Niche. S/Sgt Sakalo at the time was the south manager and Sgt Gruszka was the acting north manager; both were case managers. There is no evidence to indicate any action taken by P/C Tamminga as a result of that email and to whom he replied as his NCO, as he was directed in the email. Sgt Blanchard was not included on that email as a supervisor of P/C Tamminga.

On more than one occasion, S/Sgt Sakalo became aware of Ms. Lucier's frustrations with P/C Tamminga and this investigation. The evidence and emails of Ms. Pharand outline S/Sgt Sakalo's awareness of Ms. Lucier's calls in January 2018 and then repeatedly in June 2018.

On January 23, 2018, when S/Sgt Sakalo spoke with Ms. Lucier, he learned of her concerns about the apparent inaction by P/C Tamminga related to the investigation. His action was to task P/C Tamminga to call her. His actions when notified of Ms. Lucier's calls throughout June 2018 was to direct P/C Tamminga to call her. At each point it would have become clearer that further action was necessary. These were all lost opportunities for S/Sgt Sakalo to intervene and address the issues directly with Ms. Lucier and with P/C Tamminga. Although P/C Tamminga's actions could be described as prompt, they lacked diligence.

S/Sgt Sakalo's testimony that in January 2018 he called Ms. Lucier on P/C Tamminga's behalf and that he believed that a reminder to P/C Tamminga was sufficient, stating that he had no background with this investigation, does not make sense. He was calling Ms. Lucier as a supervisor, as she had requested through Ms. Pharand. He had approved the Niche report in July 2017, and had accessed the report on January 22 and 23, 2018 and he should have had background on the investigation and been aware of the issues with the file at this time. Although I do not find his evidence that others, not he, were responsible for this file, if that was his understanding, minimally he should have engaged those he felt were responsible, at that time.

I find in January 2018 when the list for benchmark collisions requiring updates was received from A/Inspector Quenneville and the phone call was received from Ms. Lucier, S/Sgt Sakalo was acting south manager and he promptly called Ms. Lucier. I find the issues with this file were clear and after that call in January 2018, S/Sgt Sakalo had the opportunity to diligently act at that time.

I have considered but disagree with defence counsel submissions that S/Sgt Sakalo is being held to account because he took action in June 2018 when he became aware of issues with this file. I find S/Sgt Sakalo was aware he had responsibilities related to this file. If he felt he did not, as a leader at his level, he certainly should have addressed issues with those he felt were responsible. He did not do that at any point. I find the actions he took in respect to this file involved willfulness and less than diligent efforts to ensure the file was successfully concluded.

S/Sgt Sakalo as the manager/supervisor of the TMU, was P/C Tamminga's supervisor as well as the case manager for benchmark MVCs. I concur with the prosecution submissions that the latter role took on an additional expectation. S/Sgt Sakalo would be well familiar with the implications and limitations associated to laying either *Highway Traffic Act* or criminal charges in a timely manner. I reject the submissions of defence counsel who noted the case law in relation to "*supervisors must supervise*" applied to Sgt Blanchard and not S/Sgt Sakalo.

Finding:

I find S/Sgt Sakalo did not perform his duty promptly nor in a diligent manner.

Lawful excuse for not performing the duty

There was considerable questioning and evidence in relation to the terms 'operational oversight' versus 'direct supervision.' There was evidence presented to outline a possible lawful excuse. S/Sgt Sakalo testified although he had operational oversight for the TMU, in this incident, Sgt Blanchard was responsible for P/C Tamminga's direct supervision. While this assumption was supported in part by the testimony of S/Sgt Bertram, I do not agree this is the case. I have already outlined my findings that S/Sgt Sakalo was the responsible supervisor and case manager for P/C Tamminga in relation to this file however I will further outline my findings, in relation to any "lawful excuse."

I found the evidence of Sgt Gruszka credible and reliable. He testified that as acting north manager he was responsible for the direct supervision of the TMU members. I accept Sgt Gruszka's testimony that the traffic sergeant or the platoon sergeant would directly supervise a benchmark MVC scene, for the first 24 to 48 hours but if it was a TMU member as the OIC, it would revert to him as the direct supervisor of TMU.

Sgt Blanchard's evidence too, was clear and compelling when she testified that she was not P/C Tamminga's supervisor for this or any other matter. I find this testimony credible and not a means to escape responsibility for misconduct. Through her evidence, I find Sgt Blanchard very capable and she managed what would have been a horrific accident scene, very thoroughly. I find there is no credible evidence to support that P/C Tamminga's failure to complete this investigation lies at the feet of Sgt Blanchard, Sgt Gruszka, T/Sgt Martin or A/Inspector Quenneville.

I find T/Sgt Martin's role was specialized to provide expertise to other members but I do not find he was the supervisor of P/C Tamminga or had ultimate responsibility for this file. Although S/Sgt Sakalo indicated in his testimony, it was his expectation the traffic sergeant would follow the case through to court conclusion, he later agreed in Examination by Ms. Lucier that T/Sgt Martin was not responsible for this case.

Similarly, A/Inspector Quenneville was part of a regional/divisional unit whose role it was to support traffic-related incidents. I find A/Inspector Quenneville's evidence credible and fair. Although there have been changes with the oversight of benchmark collisions since this incident, and now T/Sgts are case managers for benchmark collisions, she testified the changes were not as a result of issues with the previous system but for purposes of consistency across the province. Further, she testified that she saw no issues related to the previous process but acceded that the role of case manager was challenging for Operations Managers. She provided clear and cogent evidence of a conversation with S/Sgt Sakalo in April 2017, albeit not in relation to the collision involving Ms. Lucier but it was shortly thereafter. In the conversation, A/Inspector Quenneville clearly outlined the responsibilities of the role of case manager to S/Sgt Sakalo.

I have considered the explanation of operational oversight versus direct supervision. There is a distinction between those terms but they are not mutually exclusive in terms of roles. The evidence supports that S/Sgt Sakalo was P/C Tamminga's direct supervisor but that does not preclude another supervisor from providing direct supervision at a scene, as was done by Sgt Blanchard at the scene of the collision. S/Sgt Sakalo also had responsibility and operational oversight on various program areas and had the duties of a case manager for benchmark MVCs.

I am not impacted by the difference in schedules worked or work locations between S/Sgt Sakalo and the TMU members. OPP supervisors across the organization are sometimes responsible for the supervision of officers that may not work in the same area nor on the same shift. Responsibilities for deployed members is not unique to S/Sgt Sakalo's role. While I will agree that managing deployed members can create supervisory challenges, it was S/Sgt Sakalo's responsibility.

P/C Tamminga was ultimately responsible for failing to complete the crown brief in Ms. Lucier's matter, but the role and duty of a supervisor is to address shortcomings if the officer under their command has failed in some regard. This does not always mean discipline for the officer but the matter must be addressed. If there was someone else responsible for overseeing P/C Tamminga's work then I am at a loss as to why S/Sgt Sakalo did not engage that person. He approved the Niche report without tasking another supervisor, he contacted Ms. Lucier and later the courts when the involvement of P/C Tamminga's supervisor was requested. There is no evidence that S/Sgt Sakalo identified or engaged another supervisor through the time period outlined in the NOH. In his PSB interview, S/Sgt Sakalo did not name Sgt Blanchard, only S/Sgt Bertram as the responsible case manager.

If Sgt Blanchard was responsible then S/Sgt Sakalo could and should have addressed the issues with her as well. Further, if S/Sgt Sakalo was of the belief that S/Sgt Bertram was the responsible case manager then he could have brought this to the attention of Inspector Miller, if not S/Sgt Bertram. Neither S/Sgt Sakalo nor S/Sgt Bertram identified Sgt Blanchard as the responsible supervisor in their respective PSB interviews. S/Sgt Sakalo noted it was because he was not asked. I find this explanation unlikely as he clearly identified S/Sgt Bertram as the responsible case manager, and I do not understand why he would have hesitated to identify Sgt Blanchard as well.

Although defence counsel submitted that S/Sgt Sakalo was the author of the Information Note in relation to the issues with this case, I am not impacted by S/Sgt Sakalo's initiative in that respect as the evidence supported that the Information Note was requested by Inspector Miller after Ms. Lucier's lawyer became involved.

I have considered defence submissions that the allegations outlined in the NOH are premised on false assumptions, specifically that S/Sgt Sakalo was responsible for

benchmark collisions in the detachment area and he was immediate supervisor for P/C Tamminga. Defence counsel submitted that the MVC occurred in S/Sgt Bertram's jurisdiction and on April 9, 2017 S/Sgt Sakalo was not on duty. I agree that in the testimony of S/Sgt Bertram he made admissions that he was on the on-call Operations Manager at the time of the accident in question. In his PSB interview S/Sgt Sakalo stated that he did not follow the fatal MVC involving Ms. Lucier as it was not his fatal to follow, it was S/Sgt Bertram's. S/Sgt Bertram ultimately agreed this fatal collision was under his responsibility. Had S/Sgt Sakalo not been P/C Tamminga's direct supervisor the issue of who was the designated and responsible case manager would have been less clear.

Even considering all this, I find S/Sgt Sakalo was the one directly responsible for the work of P/C Tamminga. He was the person who was responsible for reviewing the reports filed by the constables under his supervision. Sgt Blanchard was not responsible for ensuring the accident investigation was properly completed. She was not addressed in the January 2018 email sent by S/Sgt Sakalo in respect to benchmark collision investigations requiring follow-up nor is there evidence that she received Niche task notifications from P/C Tamminga or S/Sgt Sakalo. P/C Tamminga does not report directly to her and it does not make sense that she would be responsible for the work of an officer in another unit, except if it were in relation to direct involvement such as activity at the scene of a collision wherein Sgt Blanchard was the only supervisor. If a member from another platoon at detachment were to have been assigned this fatal investigation, that member's normal supervisor would be the one responsible for approving the reports. Although each incident has unique characteristics, a supervisor, regardless of whether or not they attended a scene, would have the requisite knowledge to assess the appropriateness and thoroughness of an investigation.

The tribunal acknowledges the large span of control and the significant reporting responsibilities for the position held by S/Sgt Sakalo. However, ultimately S/Sgt Sakalo was responsible for the work of those under his command. S/Sgt Sakalo oversaw constables without the benefit of an intermediary sergeant supervisor. This set up was one that S/Sgt Sakalo himself designed. I acknowledge the testimony of P/C Tamminga who outlined that he believed a sergeant position for the TMU had been posted. With this new structure in place it will minimize S/Sgt Sakalo's span of control however it does little to minimize his wilful lack of oversight of this very serious investigation at the time.

At the time of the hearing, I was concerned about the appearance of finger-pointing in order to escape responsibility for misconduct. In respect to the evidence of S/Sgt Bertram in relation to whether he or S/Sgt Sakalo was responsible for case managing this investigation, S/Sgt Bertram in his PSB interview stated that P/C Tamminga's only ranking supervisor was S/Sgt Sakalo and that he [S/Sgt Bertram] had no oversight of this investigation. Further, S/Sgt Bertram stated that if the collision happened in his [S/Sgt Bertram's] area of jurisdiction, it would be his responsibility but as P/C Tamminga was the OIC and under S/Sgt Sakalo's supervision then it was S/Sgt Sakalo's responsibility. In his testimony, S/Sgt

Bertram's evidence was that Sgt Blanchard was responsible for ensuring P/C Tamminga properly completed this investigation. Further, he agreed in cross examination that ultimately he was the responsible case manager. I will not rely on S/Sgt Bertram's evidence in this respect.

Given my analysis and considering all of the unique circumstances in this case, I find this situation involved a lack of communication between S/Sgt Sakalo and his counterpart at the time, S/Sgt Bertram. As a best practice, S/Sgt Bertram as the on-call Operations Manager the night of the incident should have communicated with his counterpart as to clarify who would provide ongoing oversight in this occurrence, given P/C Tamminga was the investigating officer. I concur with defence counsel, that at the time of the incident, S/Sgt Sakalo was not the on-call Operations Manager. Regardless I am satisfied, based on email chains and other evidence, S/Sgt Sakalo was not only P/C Tamminga's supervisor but he took on the responsibility as the case manager at the time. S/Sgt Sakalo was engaged in arranging a case conference although other issues directed his attention from participating in that case conference. He approved related Niche reports and he also engaged with the Crown Attorney's office.

It would make sense to me that S/Sgt Sakalo would case manage this investigation as he was the supervisor of P/C Tamminga. S/Sgt Sakalo reviewed and approved the reports related to Ms. Lucier's MVC. Although there may not have been specific communication between S/Sgt Sakalo and his counterpart at the time, it would have been a waste of resources to engage a second case manager to oversee S/Sgt Sakalo who was not only P/C Tamminga's supervisor but who also had the duties/experience of case manager. S/Sgt Bertram was promoted to a new assignment in August 2017 and when S/Sgt Sakalo took over as south Operations Manager, ostensibly S/Sgt Sakalo would have taken on other duties that S/Sgt Bertram was assigned in that role. Proper supervision by S/Sgt Sakalo would equate to case management given his experience and knowledge.

In his interview with PSB, S/Sgt Sakalo responded to a question noting that ultimately he was responsible for ensuring P/C Tamminga did his job. He stated: *"...ultimately, my position as the ops manager, having the TMU under my profile, I'm responsible for what those guys do or don't do."* S/Sgt Sakalo took accountability for P/C Tamminga's work. I respect that statement and from the evidence presented at the hearing, I find that is the true state of affairs. P/C Tamminga failed to properly complete this investigation and I find S/Sgt Sakalo was ultimately responsible for the oversight of the work product of the TMU members, including P/C Tamminga.

It was submitted that S/Sgt Sakalo took accountability in June 2018 when it was clear from correspondence with the Crown Attorney's office and the law firm representing Ms. Lucier that there were problems with the file. I am left with the question as to why it took that long before he took steps to address the issue. Recognizing the clear issues at hand at the time,

S/Sgt Sakalo's efforts, to that point, lacked diligence as he just repeatedly directed P/C Tamminga to get it done without ensuring he had done so.

The human and compassionate aspects towards Ms. Lucier were lacking. She deserved better, as did her partner. When her calls were not answered by P/C Tamminga, S/Sgt Sakalo as the direct supervisor, should have inserted himself and ensured her concerns were answered. If that had been done, although there is no certainty in relation to any disposition of related charges, at least they would have been put properly before the courts; Ms. Lucier would have had the opportunity to experience justice.

A/Inspector Quenneville and her team are a much needed resource to support serious MVC's and the review and reminders were sent to Operations Managers to have responsible members' follow-up on outstanding assignments; this is a necessary check and balance.

The importance of a supervisor to assist those under their command when they are struggling cannot be overstated. According to his testimony, P/C Tamminga may have led S/Sgt Sakalo to believe that he was taking the appropriate steps to move this investigation forward. The evidence, including Ms. Lucier's calls on January 23, June 18, June 25 and June 28, 2018; P/C Tamminga's lack of Niche updates and court follow-up related to charges were evidence this was not the case. Although, ultimately P/C Tamminga is responsible for his failure to properly conclude this investigation, a dedicated and attentive supervisor could have changed the outcome of the situation; someone needed to take responsibility for the lack of activity on this file.

S/Sgt Sakalo had the duty to ensure the investigation was complete. Although unlikely, if it was not abundantly clear when S/Sgt Sakalo received the outstanding list from A/Inspector Quenneville or when he spoke to Ms. Lucier in January 2018, by June 2018 the issues with this file were crystal clear. In June 2018 after correspondence from the court staff, despite these documented concerns about the file, S/Sgt Sakalo still left it in the hands of P/C Tamminga to complete, giving him a diary date but not following up on that diary date. It was not diligent when S/Sgt Sakalo simply directed P/C Tamminga to contact Ms. Lucier.

P/C Tamminga was described as a highly motivated, independent officer by S/Sgt Sakalo but having heard testimony by P/C Tamminga and S/Sgt Sakalo, I have concerns that P/C Tamminga's inability to move forward were related to his own wellness. I agree that P/C Tamminga never came to S/Sgt Sakalo to indicate he was struggling, that he had *"too many balls in the air."* While such an admission may have assisted S/Sgt Sakalo to identify it earlier, it is the role of a supervisor to be attuned to these issues. It is important to ensure the public is well-served and that can best be accomplished if our own members are looked after first.

S/Sgt Sakalo expressed in an email to Inspector Miller in July 2018 that he did not know how this had been dragging on. Instead of, or in addition to, expressing this concern to Inspector Miller, S/Sgt Sakalo should have inquired with P/C Tamminga personally about what was going on with him. S/Sgt Sakalo had several opportunities to intervene with P/C Tamminga recognizing there were clear challenges, he needed to find out what those challenges were. Early intervention with P/C Tamminga may have significantly changed the course of this investigation. I am hopeful that in future, S/Sgt Sakalo would address similar situations differently and engage directly with the officer and any victims, to get to the root of the problem.

Finding:

Although there are some circumstances in this matter that may have impacted S/Sgt Sakalo in performing his duties, I find there was no lawful excuse for failing to supervise P/C Tamminga in the course of this investigation.

Did S/Sgt Sakalo's conduct rise to the level of misconduct or it is a mere performance issue?

Given the totality of evidence and guided by the submissions of counsel, to make a finding of guilt in this matter, I must be satisfied that there is clear and convincing evidence. To explain my understanding of clear and convincing evidence, it is greater than a balance of probabilities but less than the threshold of beyond a reasonable doubt as defined in the Criminal Code. The evidence must be so clear and reliable as to convince me the allegations are true and the facts in issue are satisfied.

In respect to an allegation of neglect of duty, I must consider if the misconduct involved wilfulness; if it was a mere mistake or if it crossed the line to neglect. It is not absolute, it must be justified.

As S/Sgt Sakalo stated to the PSB investigators ultimately he was responsible for the work of the TMU members. That is the statement of a leader and can be respected. I appreciate neglect of duty is a very serious charge and S/Sgt Sakalo had every right to defend himself. However, as the Commission in *Hewitt* highlighted, “supervisors must supervise.”³⁶ I agree with the prosecution that some of S/Sgt Sakalo's evidence was self-serving and not consistent with the other evidence. Directing responsibility at others, while not admirable, does not necessarily mean S/Sgt Sakalo is guilty of neglect of duty.

It is always important to consider the full circumstances, *Neild*³⁷ cited *Mousseau and the Metropolitan Toronto Police Force*:

³⁶ Exhibit 44, Tab 3: *Hewlett v Ontario Provincial Police*, [2007] ONCPC 7 (CanLii)

³⁷ Exhibit 44, Tab 7: *Neild v Ontario Provincial Police*, OPPHD, [15August 2016]

The reasonableness of an officer's conduct must be examined in light of the circumstances as they exist at a particular time. An officer is expected to use discretion and judgment in the course of his duties on many occasions. The police officer's discretion or judgment ought not to be examined scrupulously by the benefit of hindsight, but it is essential to examine the circumstances under which the officer exercised discretion or independent judgment to see what discretion was warranted.

I go back to the premise that police officers are held to a high standard but they are not held to the standard of perfection. S/Sgt Sakalo was in charge of a unit of constables directly reporting to him, as well as various programs. The evidence included information about the sudden death of a fellow officer from Essex detachment around the time of the case conference in May 2017.

In April 2017, S/Sgt Sakalo was involved in discussions about setting up a case conference for this MVC. On April 24, 2017, S/Sgt Sakalo received notification from P/C Tamminga that Mr. Thompson died on April 21, 2017. In July 2017, S/Sgt Sakalo reviewed and approved the related general occurrence report. He was aware at that time a death resulted from this collision. I accept the evidence of Sgt Blanchard and Sgt Gruszka that Niche does not simply rely on the input of an officer before a supervisor is able to approve something. Niche has a tasking system that would allow for a diary date. This was available to S/Sgt Sakalo to task P/C Tamminga to ensure court timelines were not missed.

I appreciate the challenges as a staff sergeant having supervision of a unit of constables and being responsible for other programs, however benchmark collisions would have a priority. S/Sgt Sakalo needed to manage this priority with more diligence rather than simply directing P/C Tamminga to contact Ms. Lucier. Up to a point I may have been able to classify S/Sgt Sakalo's conduct as a performance issue or mistake. That changed in January 2018 and I find following that time, S/Sgt Sakalo's conduct exhibited a wilfulness. His efforts to supervise P/C Tamminga and this case lacked diligence and crossed the line to misconduct.

On January 19, 2018, S/Sgt Sakalo received the chart from A/Inspector Quenneville outlining fatal MVCs requiring follow up. A couple days later, S/Sgt Sakalo spoke with Ms. Lucier and learned of her concerns about the apparent inaction of P/C Tamminga. Ms. Lucier expressed her concerns about the lack of charges; S/Sgt Sakalo would have been aware of the negative impacts of a nine month lapse since a collision, on possible charges or court proceedings.

S/Sgt Sakalo accessed the related Niche occurrence on January 22, 2018 and January 23, 2018. This was a fatal collision, outlined on a list by A/Inspector Quenneville and S/Sgt Sakalo should have been aware of the issues after speaking with Ms. Lucier on January 23, 2018, if not before. Although, S/Sgt Sakalo testified he may have hundreds of reports to

approve in a day, he acceded that few of them involved benchmark MVCs. I appreciate Operations Managers/ case managers had a challenging job but fatal collisions require the utmost care, attention and priority. Again, these were all lost opportunities for S/Sgt Sakalo to intervene and address the issues.

There is no doubt that P/C Tamminga and the OPP failed Ms. Lucier in this investigation. P/C Tamminga was primarily responsible in this respect for failing to follow through on his work commitments in respect to this investigation. Even following his testimony, I am not certain why this occurred. S/Sgt Sakalo failed however to recognize the inability of P/C Tamminga, for whatever reason, to complete the required tasks. S/Sgt Sakalo acknowledged in his PSB statement that P/C Tamminga had not given an explanation. It would appear that P/C Tamminga struggled with this investigation for some reason. It undoubtedly would have resulted in a more acceptable conclusion had S/Sgt Sakalo had a direct conversation with P/C Tamminga at any point along the way and sought out the root cause of his hesitation.

I do not concur with defence submissions that the allegations in the NOH are premised on false assumptions. I have found S/Sgt Sakalo is the responsible supervisor and case manager for this matter and he did not take appropriate supervisory action nor ensure that the investigative status was current. Through appropriate Niche tasking and supervision including direct communication, S/Sgt Sakalo should have been aware of the issues at a point earlier than June 12, 2018, when he received an email directly from court management personnel.

Although there is no evidence to support that S/Sgt Sakalo was aware of every phone message Ms. Lucier left for P/C Tamminga, there was sufficient evidence to support he was aware of her frustrations between January 2018 and June 2018. I find S/Sgt Sakalo did nothing to ensure Ms. Lucier's concerns were addressed.

My finding was that the evidence supported the proposition that S/Sgt Sakalo was not only P/C Tamminga's supervisor but he took on the case management responsibilities in this matter. I find S/Sgt Sakalo was neglectful in his duty and he willfully omitted to properly and diligently perform his duty as a supervisor and case manager. Although it is not weighty in my analysis and I am not concluding there is further misconduct, S/Sgt Bertram and others have lessons to learn from this misconduct matter. Communication between cohorts such as operations/case managers and between supervisors and their subordinates, is critical. Regardless as to who ultimately was the responsible case manager, issues of oversight must be addressed through open communication.

Best practices for anyone involved in an investigation as the supervisor or case manager, if there are changes in leadership, there should be a clear and definitive hand-off and

briefings. The responsibility is on both parties to engage in these efforts. This is a critical aspect in case management and in policing in general.

Finding:

S/Sgt Sakalo, in his role as supervisor of P/C Tamminga, should have provided clear oversight and direction on this file. I do not find the issues as outlined could be appropriately characterized as a performance issue or an error. There were too many missed opportunities to intervene and S/Sgt Sakalo's role was to supervise. He should have recognized or sought out reasons why P/C Tamminga struggled with this investigation. Although P/C Tamminga was considered a good, independent worker, everyone struggles at some time in their career and it is incumbent on supervisors to recognize when this is the situation, even without a member coming forward. There were clear signs in this matter.

I find that after receiving the January 19, 2018 email from A/Inspector Quenneville about benchmark collisions requiring action, S/Sgt Sakalo failed to properly supervise P/C Tamminga's investigation into the MVC involving Ms. Lucier. On January 23, 2018 in a call with Ms. Lucier, S/Sgt Sakalo was made aware of her frustrations and concerns about charges, nine months after the incident.

S/Sgt Sakalo failed to provide proper supervision to P/C Tamminga, considering issues of investigative delay that may impact court proceedings. It was incumbent on S/Sgt Sakalo after this call, to ensure P/C Tamminga put this case properly before the courts. S/Sgt Sakalo admitted that after nine months without charges there could be issues with delay and court proceedings.

Although there is no evidence to support that S/Sgt Sakalo was aware of every call that Ms. Lucier placed to P/C Tamminga, the evidence supports that she made her frustrations clear to Ms. Pharand, S/Sgt Sakalo and P/C Tamminga. I find S/Sgt Sakalo was aware of these frustrations in January 2018 up to June 2018 and there was no evidence that the issues were resolved. S/Sgt Sakalo did nothing to address Ms. Lucier's concerns. It was not sufficient nor appropriate to simply task P/C Tamminga to contact Ms. Lucier. Given these interactions, I can understand Ms. Lucier's evidence that she felt that the OPP did not help her, were not professional and she felt that no one cared.

I find that on June 21, 2018, the Deputy Crown Attorney, upset regarding the delay in this case, met with P/C Tamminga and S/Sgt Sakalo. Although S/Sgt Sakalo's evidence was that they were not advised at that meeting that *"due to delay there was no prospect of conviction"*, I find the email dated July 5, 2018³⁸ from Deputy Crown Paglioaroli to S/Sgt Sakalo clearly outlined that after review *"there is no longer a reasonable prospect of*

³⁸ Exhibit 43: Package of emails involving S/Sgt Sakalo and this incident

conviction given the specific circumstances of pre-charge delay in this case.” The evidence supports this particular of allegation.

I do not find the evidence supports the last bullet as outlined in the NOH, in particular, that S/Sgt Sakalo, having become aware of the involvement of a lawyer and the media, was prompted to advise P/C Tamminga to contact Ms. Lucier as soon as possible. S/Sgt Sakalo had advised P/C Tamminga to contact Ms. Lucier in emails, prior to that knowledge.

As the trier of facts, I must consider whether the totality of the evidence presented at the hearing meets the threshold of clear and convincing? The *Police Services Act* section 84(1) outlines that misconduct must be proven ‘on clear and convincing evidence.’ Although I consider S/Sgt Sakalo’s misconduct to be at the lower end of the spectrum for misconduct, I find the totality of the evidence presented at the hearing meets the threshold of clear and convincing. S/Sgt Sakalo’s conduct was neglectful.

PART V: DECISION

My analysis and findings lead me, based on clear and convincing evidence, to find S/Sgt Sakalo guilty of neglect of duty.

X 

Signed by: lisa.s.taylor@opp.ca

Lisa Taylor
Superintendent, OPP Adjudicator

Date electronically delivered: November 16, 2020

Appendix A

The following exhibits were tendered during the hearing:

- Exhibit 1: Delegation - Adjudicator Superintendent Taylor
- Exhibit 2: Delegation – Adjudicator Superintendent Bickerton
- Exhibit 3: Designation - Prosecutor, Inspector Doonan
- Exhibit 4: Designation – Prosecutor, Inspector Young
- Exhibit 5: Designation - Prosecutor, A/Inspector LePage
- Exhibit 6: Designation - Prosecutor, All Officers
- Exhibit 7: Delegation - Adjudicator Superintendent Taylor (Comm. Carrique)
- Exhibit 8: Delegation – Adjudicator Superintendent Bickerton
- Exhibit 9: Designation - Prosecutor, Inspector Young
- Exhibit 10: Designation – Prosecutor, Inspector Doonan
- Exhibit 11: Designation - Prosecutor, A/Inspector Lepage
- Exhibit 12: Designation - Prosecutor, All Officers
- Exhibit 13: Delegation – Prosecutor, Mr. A. Iafrate
- Exhibit 14: Log- Ms. Lucier's
- Exhibit 15: OIPRD Complaint
- Exhibit 16: P/C Tamminga's Duty Report
- Exhibit 17: Email starts with Tracy Blanchard, ends Stuart Bertram – 09April2017
- Exhibit 18: Email from S/Sgt Sakalo- 13June2018
- Exhibit 19: Email from P/C Tamminga to S/Sgt Sakalo – 18June2018
- Exhibit 20: Email from Sakalo to Tamminga – 20June2018
- Exhibit 21: NOH- Tamminga
- Exhibit 22: Emails re: Lucier calls – 8 pages
- Exhibit 23: Niche RMS SOP manual
- Exhibit 24: Task Summary Report
- Exhibit 25: RMS Niche Audit –Excerpt
- Exhibit 26: DVD-Audio of S/Sgt Sakalo interview – 20September2018
- Exhibit 27: Transcript of above audio
- Exhibit 28: PSB Investigative report
- Exhibit 29 Audio of Inspector Bertram interview – 28May2019
- Exhibit 30: Transcript of above audio
- Exhibit 31: Email Bertram, Sakalo – 05July2018
- Exhibit 32: Email chain – Akel, Sakalo, Gruszka
- Exhibit 33: Email chain - 14 pages
- Exhibit 34: Email chain – 2 pages – 05July2018 referencing 20February2017 email
- Exhibit 35: Email re Benchmark Collisions – 19January2018
- Exhibit 36: Command Structure/Organizational Chart

- Exhibit 37: Email 09April2017 – 24April2017
- Exhibit 38: Technical Collision / Reconstructionist Report
- Exhibit 39: Organizational Chart 03April2017
- Exhibit 40: Benchmark Collision Action Register
- Exhibit 41: Job Description – Detachment Manager S/Sgt
- Exhibit 42: Package of notes – S/Sgt Sakalo
- Exhibit 43: Package of emails involving S/Sgt Sakalo and this incident
- Exhibit 44: Prosecution Book of Authorities
 - Tab 1: *Fright v Hamilton (Police Service)*, [2002] ONCPC 9 (CanLii)
 - Tab 2: *Gottschalk v Toronto Police Service*, [2003] CanLii 85796 (ONCPC)
 - Tab 3: *Hewlett v Ontario Provincial Police*, [2007] ONCPC 7 (CanLii)
 - Tab 4: *Jacobs v Ottawa Police Service*, [2016] ONCA 345
 - Tab 5: *Mancini v Courage and Niagara Regional Police*, [2004] ONCPC 9
 - Tab 6: *Mousseau and the Metropolitan Toronto Police Force*, [1981] CanLii
 - Tab 7: *Neild v Ontario Provincial Police*, OPPHD, [15August2016]
 - Tab 8: *Neild v Ontario Provincial Police*, [2018] ONCPC 1 (CanLii)