BERNARDO INVESTIGATION REVIEW

SUMMARY

REPORT OF MR. JUSTICE ARCHIE CAMPBELL

JUNE 1996

TERMS OF REFERENCE

On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, on December 13, 1995, orders that:

WHEREAS it has been determined that it is desirable to appoint by order in council an individual to review various aspects of the investigations that led to certain charges being laid against Paul Bernardo;

AND WHEREAS it is desirable to set out the terms of reference for such a review in an order in council;

NOW THEREFORE the Honourable Mr. Justice Archie G. Campbell be appointed to conduct such a review;

AND THAT Mr. Justice Campbell's mandate be as follows:

1. to review the role of the Green Ribbon Task Force and its investigation into the deaths of the victims, and the Metropolitan Toronto Police Service investigation into the Scarborough sexual assaults;

2. to review the involvement of the Centre of Forensic Sciences and the analysis of samples submitted for DNA testing regarding the Scarborough sexual assaults;

3. to review the issues concerning the autopsies performed on Tammy Homolka and the police and coroner's investigation into her death;

4. to review the role of the Provincial Government in the provision of funding for the Green Ribbon Task Force;

5. to provide a written report to the Solicitor General and Minister of Correctional Services by March 31, 1996, comprised of an identification of issues and recommended policies or procedures that would improve the responses of the police, the Centre of Forensic Sciences and the Coroner's Office to effectively and efficiently deal with crimes of the nature investigated.

AND THAT Mr. Justice Campbell's review will consist of a review of internal reports produced by the agencies involved and additional review of the agencies involved, if required.

AND THAT all Government Ministries, Boards, Agencies and Commissions, shall assist Mr. Justice Campbell to the fullest extent in order that he may carry out his review, and that he shall have authority to engage, subject to Ministry and Government policies and

procedures with respect to the engagement of consulting services, such counsel, investigators, expert technical advisers, research and other staff as he deems it proper at rates of remuneration and reimbursement to be approved by the Ministry of the Solicitor General and Correctional Services in order that a complete and comprehensive report may be
prepared and submitted to the Solicitor General and Minister of Correctional Services.

Recommended
"R. W. Runciman"
Solicitor General and
Minister of Correctional Services

Concurred "R. W. Runciman"
Chair of Cabinet

Approved and Ordered: Date- DEC 13 1995
"H.N.R. Jackman"
Lieutenant Governor

INTRODUCTION

Between May of 1987 and December of 1992, Paul Bernardo raped or sexually assaulted at least eighteen women in Scarborough, Peel, and St. Catharines and killed three women in St. Catharines and Burlington.

Paul Bernardo is a unique type of criminal, a determined, organized, mobile, sadistic serial rapist and killer who demonstrates the ability of such predators to strike in any Ontario community. The tragic history of this case, and similar cases from other countries, shows that these predators pose a unique challenge to the systemic investigative capacity of local law enforcement agencies throughout North America and Europe. The Bernardo case proves that Ontario is no exception.

This is a review of the work done by local and provincial law enforcement and forensic agencies during the Bernardo investigations.

The Bernardo case, like every similar investigation, had its share of human error. But this is not a story of human error or lack of dedication or investigative skill. It is a story of systemic failure.

It is easy, knowing now that Bernardo was the rapist and the killer, to ask why he was not identified earlier for what he was. But the same question and the same problems have arisen in so many other similar tragedies in other countries.

Virtually every interjurisdictional serial killer case including Sutcliffe (the Yorkshire Ripper) and Black (the cross-border child killer) in England, Ted Bundy and the Green River Killer in the United States and Clifford Olsen in Canada, demonstrate the same problems and raise the same questions. And always the answer turns out to be the same - systemic failure. Always the problems turn out to be the same, the mistakes the same, and the systemic failures the same.

What is needed is a system of case management for major and interjurisdictional serial predator investigations, a system that corrects the defects demonstrated by this and so many similar cases. A case management system is needed that is based on co-operation, rather than rivalry, among law enforcement agencies. A case management system is needed that depends on specialized training, early recognition of linked offences, co-ordination of interdiscip linary and forensic resources, and some simple mechanisms to ensure unified management, accountability and co-ordination when serial predators cross police borders.

There were times during the separate investigations of the Scarborough rapes and the St. Catharines rapes and murders that the different police forces might as well have been operating in different countries. As one Metro investigator said about the way the Scarborough rapist looked in 1992, before Bernardo was identified:

“This boy is better than we might give him credit for, or he's fallen through the cracks.”

Because of the systemic weaknesses and the inability of the different law enforcement agencies to pool their information and co-operate effectively, Bernardo fell through the cracks.

The Bernardo case shows that motivation, investigative skill, and dedication are not enough. The work of the most dedicated, skilful, and highly motivated investigators and supervisors and forensic scientists can be defeated by the lack of effective case management systems and the lack of systems to ensure communication and co-operation among law enforcement agencies.

Some of the systemic weaknesses have been identified and corrected in Ontario through changes in investigative procedures and advances in the application of forensic science. Other systemic weaknesses urgently require correction in order to guard against a tragic repetition of the problems that arose in the Bernardo investigations.

Ontario has, in its existing law enforcement agencies, the essential capacity to respond effectively to another case like this, but only if certain components of those agencies are strengthened and only if systems are put in place to co-ordinate and manage the work of the different agencies.

There must be a public recognition that these problems are not just problems for the police and law enforcement communities. They are problems for the community as a whole. A commitment to correct them is necessary in order to guard against another case like this.

SUMMARY

CHAPTER 1: INTRODUCTION

The Bernardo case, like every similar investigation, had its share of human error. But this is not a story of human error or lack of dedication or investigative skill. It is a story of systemic failure.

It is easy with hindsight, knowing now that Bernardo was the rapist and the killer, to ask why he was not identified earlier for what he was. But the same question and the same problems have arisen in so many similar tragedies in other countries, because serial predators pose a unique challenge to all law enforcement agencies.

What is needed is a system of case management for major and inter-jurisdictional serial predator investigations, a system that corrects the defects demonstrated by this and so many similar cases. A case management system is needed that is based on co-operation, rather than rivalry, among law enforcement agencies. A case management system is needed that depends on specialized training, early recognition of linked offences, co-ordination of inter-disciplinary and forensic resources, and some simple mechanisms to ensure unified management, accountability and co-ordination when serial predators cross police borders.

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CHAPTER 2: THE METROPOLITAN TORONTO POLICE INVESTIGATION

Excellent investigative work was done by the Metropolitan Toronto Police Service during the Scarborough rape investigations. The difficulties faced by the investigators were enormous. Finding the rapist was like finding a needle in a haystack. There were thousands of tips including tips about suspects who looked very promising, to the extent that they devoured very significant
investigative attention and resources.

There was no lack of hard work, dedication, and investigative skill by individual officers. The investigative strategies were sound but the investigation was hampered by systemic weaknesses. There was no single person in charge at the beginning and until Superintendent Wolfe took over there was very little continuity of investigators.

Conspicuous by its absence was any system whereby senior officers monitored and followed up the investigation and set time lines and ensured follow up. Although the DNA submission went into a black hole no alarm bells went off, even when it was returned untested by the CFS because there was no monitoring or supervisory system in place to ensure follow up with the CFS and high level co-ordination when necessary.

There was no information system to ensure that all the tips called in about one suspect were put together and followed up when appropriate. The McNiff report was ignored for over two and a half years. It is discouraging that a report from an experienced officer should disappear into a hole like that. Even after other tips about Bernardo started to come in they were not put together. They were scattered throughout the files and index books and binders and desk drawers in a paper driven process described by one investigator as a nightmare. The final Smirnis tip about Bernardo, the third unrelated tip about the same
suspect, was only followed up because of the persistence of the caller because there was no system to show immediately that it was the third separate tip about the same suspect. There was no consistent organized system for suspect classification and elimination.

The problems that arose from lack of a case management system show that motivation, investigative skill, and dedication are not enough. The work of the most dedicated, skilful, and highly motivated investigators and supervisors can be defeated by the lack of an effective case management system.

Communication between police forces was inadequate. There was at that time no ViCLAS automated crime linkage system in place. There was not even any system to ensure that the zone alert from the Henley Island rape was considered by the Metro investigators, a zone alert that would have suggested strongly to any experienced investigator that the Scarborough rapist was
operating in St. Catharines. There was no system to put that information together with the fact that Bernardo, one of the Scarborough rape suspects, had moved to within a mile of the strikingly similar Henley Island rape. There was no system in place to

recognize that the Scarborough rapist was still operating almost next door. There was no system to ensure full communication between Metro and GRT when GRT inquired about Bernardo as a Scarborough rape suspect. So far as
Bernardo was concerned, the Metro force and the GRT might as well have been operating in different countries.

The chase of a suspect from a stakeout on May 25, 1988, now believed to be Bernardo, and the rape by Bernardo four days later in Mississauga suggests that serial predators will move their base of operation to avoid a tightening police cordon.

When the Scarborough rapes stopped, the investigation wound down and Metro put it on the back burner because of competing workload from other recent sexual assaults. There was no provincial system in place to recognize that serial predators are mobile, and to ensure that the investigation was continued vigorously after the local police force no longer considers it a priority. There was no system in place to recognize a wider public interest in tracking down the predator, wider than the interest of Metro taxpayers but just as high in priority for the residents of other communities at risk from the mobile serial predator.

When Bernardo stopped stalking and raping in Toronto and started stalking and raping and killing in St. Catharines and Burlington he might as well have moved to another country for a fresh start.

CHAPTER 3: THE CENTRE OF FORENSIC SCIENCES

Bernardo's samples were submitted to the CFS on November 21, 1990 for conventional serology testing and, if the serology was right, for DNA testing. The serology results on December 13, 1990 showed that his serology was right for DNA testing. Thus on December 13, 1990, the CFS had a written request from Metro to test Bernardo's sample for DNA.

Despite this request for DNA testing, effective December 13, 1990, Bernardo's test results were not obtained until February 1, 1993.

It appears that Bernardo's DNA submission went into a black hole at the end of 1990.

The overall delay between December 13, 1990 and February 1, 1993 was over 25 1/2 months. If the five suspect samples including Bernardo's had been given the highest priority on December 13, 1990, the DNA match to Bernardo could have been found in early January 1991.

The CFS test of Bernardo's DNA sample on February 1, 1993 led to his arrest and prevented him from raping or killing again.

The tragic converse of this fact is that Bernardo, during the 25 1/2 months his DNA was waiting to be tested, raped four young women and raped, tortured, and murdered two others. In hindsight, it is clear that these rapes and murders could have been prevented if Bernardo's DNA sample had been tested by the CFS within 30 or even 90 days of the December 13, 1990 serology test.

The underlying reason for the delay was the limited capacity of the DNA lab during its start up period to conduct the labour intensive and time consuming RFLP DNA tests in a timely fashion in the face of a heavy work-load. This was compounded by the lack of any supervisory system within the Metro police department to ensure that the case was monitored and followed up
vigorously at a higher level, and by communication problems between the CFS and the Metropolitan Toronto Police and within the CFS itself.

At the heart of the tragedy was a systemic failure. There was no system to recognize that the Scarborough rapist was going to kill someone and to give the case a high level of co-ordination among all agencies involved in the investigation. For Metro and the CFS it was business as usual. The people working on the case had no mandate or direction to set everything else aside and
stop the Scarborough rapist before he killed someone. After he stopped raping in Toronto, he naturally became a lower priority in Toronto. There was no system to recognize that a serial predator like Bernardo is not just a problem for Toronto but also for every other community he may move to when things get too hot for him at home. There was no system to recognize a wider

public interest, in the apprehension of a serial sexual predator, beyond the parochial interests of one particular community.

It was known that serial predators don't usually stop unless they are dead or in jail.

Yet there was no system in place to drive this case forward to the top of the priority list or to leapfrog it ahead of other serious sexual assault and murder cases. There was no case management system in the Metro force to supervise this cold case and drive it forward vigorously. There was no strategic co-ordination of the work of the different agencies involved in the
investigation. No one assumed the responsibility to push Bernardo's DNA test ahead because there was no system to priorize and urgently drive forward the investigation of this violent escalating mobile serial predator.

To meet the additional work-load created by the Criminal Code amendments and to reduce the DNA testing delay to a reasonable turnaround time in the range of 30 days, additional funds for the CFS are urgently required.

The recent announcement of the expansion of the CFS testing capacity, from 26 scientists to 52 scientists, and the increase in testing capacity from 400 cases a year to two thousand cases in the next few years, is encouraging and it demonstrates a welcome recognition that public safety must receive a high priority even in times of fiscal restraint.

From a financial point of view, the Bernardo case demonstrates that delays in DNA testing can cost millions of dollars in the investigation of offences that could be prevented by timely DNA testing. Again from a financial point of view, there is a rapidly developing body of law around the potential legal liability of government for failing to provide a reasonable standard of public
protection, an area of liability which could prove very expensive to the government if reasonable standards are not met.

And most importantly, the Bernardo case demonstrates that delays in DNA testing can imperil personal safety and cost lives. Any reluctance, to continue to spend the public funds necessary to maintain a reasonable turnaround time for DNA tests must give way to a consideration of the financial and human cost of failing to do so. The planned expansion of the DNA lab at the
Centre of Forensic Sciences demonstrates that this has now been recognized.

It will be difficult for the government to continue to commit the necessary funds to achieve and maintain a reasonable turnaround time in the range of 30 days for DNA testing. But the Bernardo case, in terms of the government's obligation to provide a reasonable standard of public protection, demonstrates that the public will remain at unnecessary increased risk from violent
serial predators unless a reasonable turnaround standard is maintained for DNA testing.

CHAPTER 4: THE SECRET KILLING OF TAMMY HOMOLKA

It was inappropriate for the coroner, Dr. Rosloski, to submit a final report showing death by natural causes when there was a dramatic and unexplained second degree burn over much of Tammy's face, inappropriate to report that she died by means of natural causes when he did not know how she died, and inappropriate to list asthma as a cause of death when he had no evidence that asthma caused or contributed in any way to her death.

This is all said with the benefit of 20 - 20 hindsight and it should be noted that Dr. Rosloski, apart from the mistakes noted above, performed his duties conscientiously and put a significant degree of effort into the investigation. It was at that time acceptable for a coroner to list aspiration of vomit as a cause of death but that practice has been changed and aspiration of vomit is no longer accepted by the coroner's office as a cause of death without a good explanation of the underlying cause.

I cannot say that there was any breach of duty by NRPS officers. It is clear however that there was bad communication between Weeks and Mitchell and Weeks did not communicate all his suspicions to Mitchell. It is also clear that there was a major discrepancy between the 15 - 20 minute wait before the 911 call that Bernardo described to the ambulance drivers and the 2 - 3 minute wait he described to Mitchell, a major discrepancy that Mitchell did not investigate although he knew there were suspicions about the delay. He accepted Bernardo's explanation of the discrepancy too easily, without checking readily available sources of highly credible information that would have starkly contradicted Bernardo.

Had Weeks' private suspicions or Bernardo's contradiction about the 911 call been followed up, there would have been further questioning of Bernardo and Homolka although it is speculative to suggest that further questions of them would have led to the truth. It is also possible that if the death had been recorded as undetermined this would have led to greater suspicion of Bernardo by Sergeant Nesbitt in his May 1992 investigation of Bernardo although, again, it is speculative to suggest this would have led to a different result.

The question of the unexplained burn, although it was picked up by Dr. Groves and referred to Dr. Hillsdon-Smith, was left hanging without any resolution and there was apparently no follow up with a dermatopathologist although that was raised as a possibility by Dr. Hillsdon-Smith. The work of the pathologists on the burn was done in apparent isolation from the coroners and other investigators and without any attempt at a collaborative or team or inter-disciplinary approach. It appears that the role of the pathologists was somewhat isolated and certainly not fully integrated into the death investigation system. This may have accounted in part for the lack of follow up in respect of the burn and the fact that the case was closed without any explanation for the burn.

It would be guesswork to speculate what might have happened differently if Tammy's death had been treated more suspiciously and reported differently. If the Halothane bottle and Halcion container had been found, that would have focused further inquiries on Bernardo and Homolka, and had the videotape of the sexual assault on Tammy been seized, that obviously would have
exposed the homicide. But short of that, and in the absence of any basis to conduct a forensic search of the Homolka house, further questioning of Homolka and Bernardo would probably have led nowhere having regard to their proven ability as smooth and accomplished liars, the lack of any evidence with which to confront them and the lack of any leverage in the hands of the police. It seems unlikely, for the same reasons, that a coroner's inquest would have yielded anything different although it might have focused more attention on the medical mystery of the unexplained burn and driven Homolka and Bernardo to further explanations.

Had Tammy's death been classified as unexplained, as it would be now, it would have come to the attention of the Green Ribbon Task Force when they did a Niagara police records check of Bernardo after the Haney tip in early May of 1992, and this might have heightened their scrutiny of him as a possible suspect. There is, however, no reason to believe that Metro at any stage of its investigation would have learned about Bernardo's involvement in an undetermined death in St. Catharines.

A number of changes have been made by the Chief Coroner's office in the system of death investigation as it existed at the time of Tammy Homolka's death. The changes include training, emphasis on the category of undetermined death, a direction that aspiration of stomach contents is not in and of itself a recognized cause of death, the introduction of team reviews and inter-disciplinary evaluations of all cases where there are unresolved concerns, and improvements in the organization of the forensic pathology service.

CHAPTER 5: THE HENLEY ISLAND ATTACK

The modus operandi of the Henley Island rape on April 6, 1991 in St. Catharines was strikingly similar to that of the Scarborough rapist. These details were so obviously alike that an experienced investigator with detailed knowledge of the Scarborough attacks would immediately conclude that the Henley Island attacker was probably the Scarborough rapist.

We now know that it was not just a carbon copy of the Scarborough rapes. The Henley Island rapist was Bernardo, one of Metro's Scarborough rape suspects who had moved to St. Catharines and lived, unbeknownst to the Niagara Police or the GRT, within a mile of the attack scene. Unfortunately, there was no system in place to ensure that these vital pieces of information, all readily available in the hands of various police forces, were ever put together in a way that they could be used by the investigators.

The Henley Island case does not raise any concerns about the quality of the local criminal investigation. The problem is that there were no systems to ensure that the obvious link to Scarborough was recognized and to ensure, once local leads were exhausted, that the scope of investigation widened beyond local boundaries. Had there been such a system in place, the
investigators, after exhausting local leads would have asked where the predator came from and where he might go next. They did what they could with the systems then in place, including the C.P.I.C. zone alert, but that system was not supported by procedures to ensure that investigators got its benefit.

Had the ViCLAS system been in place and fully used at that time, it would immediately have suggested a link between the Scarborough and Henley Island rapes. It would have enabled the separate investigations to pool their resources and focus the two investigations in the direction of the common attacker.

But there were no systems in place to compel recognition of the link. So far as the Scarborough rape investigation and the Henley Island rape investigation were concerned, Metro Toronto and St. Catharines might as well have been in different countries.

CHAPTER 6: STALKING

Bernardo was a predator who stalked his victims.

After he stalked and raped the young women in Scarborough between 1988 and 1990 and after he stalked and raped a young woman on Henley Island on April 6, 1991, and after he stalked and raped and murdered Leslie Mahaffy in June of 1991, he stalked and terrified a number of young women in St. Catharines in the summer of 1991 and the spring of 1992, before he stalked and raped and murdered Kristen French.

Stalking was a hallmark of his method. The young women he stalked in St. Catharines took the initiative to report Bernardo's stalking to the NRPS. Regretfully, the police did not take Bernardo's stalking seriously. There was no investigative follow up. The police information about Bernardo's stalking was not properly reported and not properly organized and not retrieved
although it was potentially significant to the investigations of the murders of Leslie Mahaffy and Kristen French. One of the young women re-sighted Bernardo in his car on April 18, when Kristen French was being held captive, and reported it to the Niagara Regional police, although she was not able to get the correct licence number and the police took no notice of her follow up report.

That question, whether Kristen French would be alive if the stalking incidents had been followed up, is unanswerable. There are too many unknowns.

The most significant problems were that the officer who investigated Bernardo as the August 1991 stalker did not report the incident and that the re-sighting of Bernardo on April 18, 1992 was apparently not taken seriously when the call was received by the police. Underlying those problems was the more fundamental problem that stalking, until recently, was not taken very
seriously either by the police or by the public.

Although stalking is now taken more seriously, and is increasingly recognized as one of the hallmarks of the serial predator, much remains to be done by the way of police training and by way of raising public consciousness about its seriousness. It is questionable, having regard to the wording of the Criminal Code stalking amendment and its restrictive judicial interpretation,
whether Bernardo's stalking of the young women in St. Catharines would be caught by the Criminal Code stalking amendments, although the judicial interpretation of those provisions is not yet completely settled.

Having noted the underlying reasons why Bernardo's stalking of the young women in St. Catharines was not taken seriously by the NRPS, and having noted that there have been general improvements in police response to stalking since then, it remains to be said that the Niagara Region Police Service should have been more responsive to Bernardo's stalking of the young women in St. Catharines in the summer of 1991 and the spring of 1992, and to his re-sighting on April 18, 1992. The incidents themselves

deserved more attention because of the justified fear of the victims and the inherent danger implicit in the stalking. The incidents deserved even more attention at a time when the local police force was looking for Leslie Mahaffy's killer, just four months after a vicious stalking rape a few miles away on Henley Island. Although it is impossible to calculate the impact upon the Bernardo investigations of this lack of attention, it is obvious that the information would have been of interest to the GRT investigations because that was the very kind of information they had tried to obtain from the Niagara Regional Police Service.

CHAPTER 7: THE GREEN RIBBON TASK FORCE INVESTIGATIONS

The GRT investigation was characterized by tremendous dedication and a great deal of investigative skill, hampered by the lack of adequate case management systems.

It is a model of co-operation between police forces, originally Niagara Region and Halton Region, and ultimately a dozen police forces working together co-operatively under unified leadership.

The paint and cement investigations of the materials used to dispose of Leslie Mahaffy's body displayed great investigative ingenuity and led to the source of the cement, but these investigations were hampered by the lack of a standard system to ensure that the cement cash return slips were checked as a matter of course.

The Camaro turned out in hindsight to be a red herring. But the Camaro sightings at Kristen French's abduction scene were the only things the investigators had to work with. Although it was appropriate for the investigation to focus on the only evidence that was available, the lack of standard interview techniques may have affected the extent to which the investigation focused on
a Camaro instead of other similar cars. The decision to extend and continue the Camaro investigation, and the usefulness of the checking of Camaros through the windshield sticker programme are issues which, in hindsight, might have been addressed differently had there been a system in place to ensure, in advance, the capacity to deal effectively with the information received from the Camaro investigation.

Although it did not effect the thoroughness or competence of the post mortem examination, the working relationship between the police and the forensic pathologists could have reflected more team-work and inter-disciplinary co-ordination.

The relations between the GRT and the media industry were very bad, because of the inadequate NRPS media policy then in force, the lack of a full-time media liaison officer, and frustration by the GRT officers with the conduct of some media representatives that appeared to them to border on obstruction of the investigation.

The suspect classification and elimination system was essentially sound but there was no machinery in place to ensure its consistent application. One glaring example of this problem is the confusion as to whether Bernardo was classified as a 3C
suspect or a 1C suspect throughout the investigation. Another example, although there is no indication that it would have affected the outcome, is the fact that Sergeant Nesbitt did not attempt to check Bernardo's alibi for Easter weekend and that he did not contact Metro police for suspect information about Bernardo before interviewing him.

The communication between GRT and the Metro Force about Bernardo was inadequate. Metro could have given GRT more information and GRT could have asked Metro for more information. There was no case management information system to

ensure the effective communication of suspect information between the two police forces.

The information management systems available to the GRT were inadequate. The investigation was overwhelmed with tips it could not handle because the public appeals for information were not linked with the planned capacity to handle the volume of public response. Like Metro, the GRT had no case management information system to ensure that tips like the I. L. tip and the
Haney tip were put together so the investigators could see, when a tip came in, that there had already been another tip about the same suspect.

These problems were compounded because NRPS personnel did not report Bernardo's stalking or re-sighting and this potentially important information never came to the attention of the GRT.

Not only were the case management information systems within Metro and the GRT inadequate, but they had no way to put together the information they had both received about the same suspect. One wonders how many times Bernardo had to be reported to the police before all the police information about him was put together in one place. It was only after his arrest that
all the information about him, readily available in the hands of both police forces, was put together. An effective system puts this information together during the investigation, not after the arrest. As noted above, Metro and the GRT might as well have been working in different countries so far as Bernardo was concerned, and Bernardo slipped through the net.

It is guesswork to speculate on what might have happened differently had there been an effective case management and information system in place during the GRT investigation, combined with similar systems within the Metro force and effective communication between the various law enforcement agencies. Certainly if these systems had been in place at the time the
connection could have been made between:

- Bernardo's statement to Irwin in November of 1990 that he was moving to St. Catharines
- the striking similarities between the Scarborough and Henley Island rapes
- his residence within a mile of the Henley Island rape
- the McNiff, Smirnis, Royal Bank, Madden and I. L. tips
- appropriate follow up investigation on these tips
- the stalking incidents earlier reported to the NRPS
- Bernardo's return of the cement

All this information was readily available but there was no system to put it together and it got lost in the overall mass of investigative information. What is clearly needed is a systematic case management approach that taps into every available technique and

resource and source of information and organizes the information in a way that it can be recognized and used
effectively by investigators.

So far as leadership is concerned, Inspector Bevan did what he could with the systems available to him. He is to be commended for his first rate skills as an investigator, his team-building ability, and his tireless dedication and commitment to the work of the task force.

CHAPTER 8: IDENTIFICATION, ARREST, QUESTIONING

Despite some thoughtful planning, the arrest and questioning of Bernardo was a mess from beginning to end because there was no effective co-operation between Metro and the GRT, because Metro officers were operating on their own private agenda, and because no one was in charge and no one was accountable. Although it was planned to give the accused a phone call to his lawyer immediately after arrest, this was not done. Not only was it not done, but this crucial information was not conveyed to the interview team. The interview team of Detective Irwin from Metro and Detective Beaulieu from GRT was inadequately prepared. Although Beaulieu tried to meet with Irwin to work out a team strategy for the team interview, Irwin had no time because he had been assigned to the search warrant preparation and his senior officers did not ensure that he was given time for joint preparation with Beaulieu. Although his ranking officer Staff Inspector Marrier did not ensure that Irwin consulted with Beaulieu, he did ensure that Irwin took private direction and strategic advice about the conduct of the interview from other Metro officers, strategies and advice which Irwin did not disclose to Beaulieu. The Metro officers, unknown to the GRT, proceeded with their own private agenda. This reflects an astounding and dangerous lack of co-operation between police forces.

So far as the interview itself was concerned, the plan was for Beaulieu to start out by questioning Bernardo about the murders and then for Irwin to question him about the rapes. Irwin, apparently acting on his own agenda, suddenly and without warning departed from that plan and immediately took over the interview by confronting Bernardo about the rapes, leaving Beaulieu no choice but to leave the room, stop Irwin and risk an altercation in front of Bernardo, or keep quiet and let Irwin do his own thing. He chose to remain silent and take notes.

About the content of the interview itself there is little to be said except that it began badly, degenerated into an argument, continued badly, and ended badly. Nothing of value was ever gained from the interview.

Although the accused repeatedly tried to invoke his right to counsel, Staff Inspector Marrier told the interview team to proceed in the face of repeated requests to contact counsel, assuring them that this course of action was supported by legal case law. This grossly incorrect legal advice by Staff Inspector Marrier ensured that no evidence discovered as a result of the interview could be used against Bernardo.

The degree of disorganization and the inability of the various police forces to co-operate, even to the basic extent of ensuring that the video camera was loaded and the audio tapes were not lost, is difficult to fathom.

It is not hard to tell what went wrong. The precipitating cause of the problems was the media leak which led to the premature arrest and interview before the police were ready.

Underlying causes included:

- the legal problem discussed above, that there was strong evidence on the rapes but virtually no evidence on the murders until the search warrant documentation was completed;
- the lack of a ready made running synopsis of the investigations that could be quickly whipped into shape as the basis for the search warrant documentation, leading to a lengthy delay;
- the ego clashes, turf competition, and inherent rivalry between police forces, a natural everyday fact of police life, which got in the way of effective law enforcement;
- the fact that no senior officer in a position of authority ensured that there was an agreed team interview strategy and adequate joint preparation by the interview team;
- the astounding fact that the Metro officers were following their own agenda for the interview, which they did not disclose to the GRT. For Irwin to go into the interview with an undisclosed interview agenda, an agenda he had never disclosed or shared with his interviewing partner, was a prescription for disaster;
- the grossly incorrect legal advice given to the interview team by Staff Inspector Marrier; and
- the fact that there was no one in charge, no one accountable, no effective co-operation between the police forces, and no co-ordination of their work so far as the interview was concerned.

As noted above, if there was ever an abject example of how things can go wrong when police forces do not co-operate and no one is in charge or accountable, this is that example.

And again, if there was ever an abject example of why it is necessary to develop a co-operative approach among police forces and a system to ensure such co-operation and accountability under a unified leadership structure, this is that example.

But it is also an example of how things can work well when a spirit of co-operation is demonstrated from the top down throughout a police organization. The improvement in the working relationships, when Metro sent Detective Sergeant Boyd and Detective Sergeant Warr to work with GRT on site in Beamsville, demonstrates that an attitude of professionalism and

co-operation from the leadership of a force can overcome the inherent inter-force rivalry and turf wars that are an everyday fact of police life.

As noted above, senior officers in positions of authority need more than investigative and administrative skills. Team building and professional skills of the kind demonstrated by Inspector Bevan in the leadership of the Green Ribbon Task Force, professional and peace-making skills of the kind demonstrated by Detective Sergeant Boyd and Detective Sergeant Warr in the
aftermath of the initial Metro-GRT clashes, and leadership of the kind demonstrated by the Metro force when it sent Boyd and Warr to work together with GRT, are essential to the success of any co-operative police venture.

Communication and co-operation between agencies at all levels must be accepted, encouraged, directed and, above all, practised. If not, every other measure, effort, venture, and joint force operation is doomed to failure.

CHAPTER 9: THE SEARCH OF 57 BAYVIEW DRIVE

In the absence of any evidence to the contrary I proceed on the assumption, although it has not been verified or proven, that the crucial 8 mm. videotapes were recovered from the ceiling area above a potlight in the upstairs bathroom at 57 Bayview Drive in the manner attributed to Mr. K. Murray in public statements.

At the time of writing, Murray is the subject of an O.P.P. criminal investigation, announced in November 1994, into his conduct in relation to the tapes. The O.P.P. informed this review it would interfere with their investigation if we were to question any of their potential witnesses, and we have refrained from doing so. This part of the report is written on the assumption that public statements about Murray's removal of the tapes are accurate. It is written without the benefit of any information from Murray or those associated with him in the removal of the crucial evidence from the murder scene.

The house was under police surveillance when Murray left the house on May 6. Although the police have been criticized for letting him leave with the tapes, they had no grounds to stop and search Murray on his way out of the house. They never considered doing so. They had no reason to believe the tapes were still in the house when Murray went in. In any event, they had no grounds to believe that an officer of the court would remove from a murder scene real physical evidence hidden by the accused.

The search produced very significant evidence and was generally a model of painstaking and detailed thoroughness. Notwithstanding this success, the critical issue hanging over the entire search is that it failed to produce the crucial videotapes of the rape and torture of Leslie Mahaffy and Kristen French and the rape of Tammy Homolka.

There is much to be said for the police point of view expressed by Sergeant Beaulieu in his paper prepared for the FBI academy at Quantico and reproduced in Appendix 13:

Unfortunately for the personnel who conducted this search, it is not their dedication, tenacity and professionalism that is remembered by most, but rather the regrettable misfortune of the missed videotapes.

The failure to find the tapes had a critical impact on the course of the prosecution because the plea bargain with Homolka would not have been made if the police had found the tapes.

In considering the failure to find the tapes one must bear in mind the information available to the police and their state of knowledge during the search; they had not yet had the opportunity to speak to Homolka about the tapes, they had no evidence that the tapes were still in existence, and they had some reason to believe that the tapes were no longer in the house.

The immediate cause of the failure to find the tapes, assuming they were in the potlight area, is that Constable Kershaw did not reach far enough into the sealed attic cavity. It

is now apparent with the benefit of hindsight, with the advantage of knowledge unavailable to him at the time, and with the benefit of Murray's statement (assuming it is true) that he was able to reach in and find the tapes, that Constable Kershaw erred in failing to search the area more thoroughly. It goes without saying that hidden things are much easier to find when you know where they are, than when you don't know where they are and when there is reason to believe they are not there, and when there is even some doubt whether they exist.

A less immediate but underlying impediment that restricted the scope of the search was the restricted mindset of the searchers. The searchers' mindset was restricted by the application of very strict Charter of Rights minimization principles which strongly discouraged physical damage, such as tearing down the ceilings around every potlight in the house and tearing up every floor
and wall in the house, in the absence of some specific evidence to justify it. The searchers' mindset may also have been restricted by the limits of their expertise and experience as crime scene identification officers, contrasted with the expertise and experience of officers such as drug officers who specialize in seeking out and finding things hidden in obscure places.

CHAPTER 10: THE JANE DOE VIDEOCLIP

The report of the Honourable Patrick Galligan on the Homolka plea arrangement referred to an issue that arose from the police questioning of Homolka, on May 16, 1993, about a photograph of a young woman who was assaulted by Bernardo. The young woman was befriended by Homolka, who helped Bernardo drug her so he could sexually assault her when unconscious on two occasions in 1991, probably June 7, 1991 and August 10, 1991.

The reason they did not show her any other photographs is because they did not have any.

The first reason they did not show her the videoclip, from which the photograph was taken, is because there was no reason to do so. There was no reason to explore further the identity of the unidentifiable person in the blurred videoclip or to explore Homolka's memory about it because the police at that time had no reason to believe it was anyone other than Kristen French or
perhaps Tammy Homolka.

The second reason they did not show her the videoclip was because the police at that time did not have the videotapes of Kristen French or Leslie Mahaffy, although Homolka thought they did, and they did not want to show Homolka (who had earlier demonstrated a strong capacity for lying and manipulation) the weakness of their position, or to influence her testimony or to give her a chance to lie, by showing her at that time that they only had a one and a half minute videoclip. In order to keep Homolka as honest as they could, the police had to maintain the upper hand and they had valid reasons for proceeding as they did.

CHAPTER 11: SEXUAL ASSAULT VICTIM CONCERNS

The strongest impression from the interviews is the thought and care with which the victims expressed their observations and concerns about their experience in the investigations. Their experience varied, depending on the individual officers and victim support workers they dealt with. Many of the themes were common:

- the need for sensitivity on the part of the initial response
- officers and throughout the investigation;
- the tremendous difference that police sensitivity and training can make for the victim;
- the positive response to effective victim services;
- the need to be informed regularly of the progress of the investigation and to learn of major events before hearing about them from the media;
- the importance of continuity of investigators;
- the importance of training and interview techniques to ensure initial full disclosure of the details of the attacks;
- concerns about the media
- frustrations with the court process.

The most important conclusion from all of this is the importance of training for all officers involved in the response to and investigation of sexual assaults, and the tremendous advantage for the victim of a consistent system of support, continuity, and information about the progress of the investigation and the prosecution.

CHAPTER 12: CISO: THE CRIMINAL INTELLIGENCE SERVICE OF ONTARIO

The provincial government provided partial funding for the Green Ribbon Task force through the Criminal Intelligence Service of Ontario ("CISO"), a co-operative of seventy-five Ontario law enforcement agencies including all of the larger police forces in the province.

The CISO funding process operated, in respect of the Green Ribbon Task Force, as it should have. The standard CISO funding proposals and documentation generated five payment authorizations under s. 9 (2) of the Ministry of Treasury and Economics Act, the first on May 14, 1992 and the last on April 20, 1995. The numbers are summarized in the chapter. Some
of the later expenditures included prosecution costs, because of the immensely labour intensive demands on the Crowns and police in sifting through the massive documentation of five years of investigative work and in preparing for a case that was potentially very complex.

It is impossible to calculate the total financial cost of the Bernardo investigations. Some help is available in the form of CISO accounting of the provincial funding allotments and an estimate of the policing costs absorbed by the individual police forces involved in the Green Ribbon investigation and prosecution phase. But it must be emphasized that the policing costs are rough
estimates only. They do not include all indirect expenditures or externalized costs. In particular, they do not include the massive five-year Metro police expenditure on the Scarborough rape investigations, which would be impossible even to estimate with any degree of accuracy.

Given the proven experience throughout the world that inter-force rivalry is a major obstacle to the successful investigation of mobile predatory criminals, any Ontario system should draw on the unique strengths demonstrated by CISO model. Those unique strengths include its proven operational track record, its ability to secure co-operation between police forces by reason
of its neutrality and credibility in the police community, its strict accountability and lack of bureaucratic baggage, and its demonstrated ability to achieve buy-in from the chiefs, senior management, and officers of the co-operating police forces.

CISO provides a proven, ready-made model that can be readily adapted for the co-ordination and management of serial predator investigations without the creation of a whole new bureaucracy. The CISO model requires some special adaptation to the unique problems of investigating mobile serial predators, particularly by way of case management support structures and a focus on inter-disciplinary teamwork and training. This required emphasis on special case management systems, training, and the forensic, medical and scientific teamwork required for serial sexual predator investigations, will be discussed in the recommendations section.

CHAPTER 13: A STRATEGIC DEFENCE AGAINST SERIAL PREDATORS

This chapter is summarized in the Summary of Recommendations.

SUMMARY OF RECOMMENDATIONS

Introduction

1. A major case management system is required for major and inter-jurisdictional serial predator investigations, based on;

- co-operation rather than rivalry
- specialized training for senior officers in charge, senior investigators, and inter-disciplinary support teams
- early recognition of linked offences
- co-ordination of inter-disciplinary and forensic resources
- simple mechanisms to ensure unified management, accountability and co-ordination among police forces and law enforcement agencies

2. A commitment for change is required from the police and law enforcement communities, the Ontario government, and from the community at large

Metropolitan Toronto Police Investigation

3. A major case management system for the investigation of serial predators is required to ensure:

- unified direction under one single person in overall charge of, and accountable for, related investigations
- supervision of time lines and systematic follow up of crucial investigative steps such as forensic testing
- a standard computerized case management system the recording, organization, management, analysis, and follow up of tips and investigative leads
- the consistent, and organized classification and elimination of suspects
- the systematic use of relevant information from other forces such as C.P.I.C. zone alerts
- co-operative provincial oversight and intervention when a serial predator investigation is not pursued vigorously when it becomes a low priority for a local police force

The Centre of Forensic Sciences

4. A reasonable turnaround time for DNA testing is required, in the range of 30 days

5. A continuing commitment of resources is required to achieve and maintain this turnaround time in face of technological change and rising workload

6. A system is required to better co-ordinate the work of forensic scientists and police investigators

The Secret Killing of Tammy Homolka

7. Continuation and support is required for the work of the Chief Coroner's office in developing, for unexplained or suspicious deaths, an inter-disciplinary approach to integrate the work of the police, coroners, forensic scientists, and forensic pathologists

The Henley Island Attack

8. A case management system is required to ensure that investigations of sexual predators widen their scope once local leads are exhausted

9. Mandatory ViCLAS reporting is required to ensure early recognition of links between sexual predator attacks

Stalking

10. Increasing awareness and training are required to ensure that stalking is recognized as a serious problem and a potential hallmark of the serial predator and that reported incidents are responded to and documented in accordance with approved procedures.

The Green Ribbon Task Force

11. A major case management system is required to ensure that all relevant resources and techniques and information sources are applied to the investigation

12. A standard computerized case management information system is required for major sexual assault and homicide investigations that have the potential to involve inter-jurisdictional investigation

13. A major case management system is required to ensure:

- standardization of interview and statement techniques and consistent criteria for suspect classification and elimination better communication between police forces about common suspects
- strategic analysis of the benefits of major initiatives and the capacity of the investigation to use the resulting information effectively
- a high degree of mutual understanding and agreement between police investigators and forensic pathologists on the steps to be taken at a body site and during a post mortem investigation

- effective media relations policies directed in major cases by a specially trained full time media relations officer

Identification, Arrest, Questioning

14. A major case management system is required to ensure:

- that one single specially trained officer is in clearly in charge of, and accountable for, the planning, strategy, and execution of the arrest and interview as well as all other aspects of the investigation
- that a detailed running synopsis of the investigation be maintained in a form that can be quickly adapted as a core document as a basis for the preparation of search warrant and other legal documentation
- that all officers involved in the arrest and questioning of a suspect, from the most senior to the most junior, are aware of the legal requirements for a valid arrest and questioning and the legal consequences of failing to comply with those requirements
- that the officer in charge be responsible for the co-ordination of all advice and direction given to the arresting and interviewing officers

The Search of 57 Bayview Drive

15. The officers who conduct major searches should be selected based on their experience and expertise and there should be an effort to combine officers from different areas to ensure the best results. A second team of searchers should be sent in after the first group has exhausted all apparent possibilities.

Sexual Assault Victim Concerns

16. Sexual assault case management systems and sexual assault investigation training are required to emphasize:

- sensitivity to the special concerns of sexual assault survivors and the potential for revictimization through the investigative,
- prosecution, and judicial processes
- continuity of contact between investigator and victim
- availability of victim support services
- interview techniques that encourage full disclosure of the assault and its circumstances
- keeping victims informed of the progress of the investigation and the case

CISO: The Criminal Intelligence Service of Ontario

17. A province-wide co-ordinated response to serial predators is required, based on the CISO model of a centrally supported police co-operative with additional inter-disciplinary advice and support, but without the creation of a new agency or the attraction of any bureaucratic baggage

A Strategic Defence Against Serial Predators

18. A co-ordinated case management system is required that transcends any localized mindset, discourages tunnel vision, recognizes that the capture of a serial predator involves a provincial public interest wider than the interest of any single community or police force, and encourages unified investigations with clearly defined leadership and accountability

19. A co-ordinated early recognition system is required to recognize links between crimes early enough to pool information and converge the separate investigations onto the same target, a system based on;

- more effective utilization of C.P.I.C. zone alerts and C.P.I.C. off-line searches
- mandatory ViCLAS reporting by all Ontario police forces, by regulation under the Police Services Act, supported by training, reinforcement, and any resources necessary to support expanded ViCLAS reporting
- the use of the Chief Coroner's records of unidentified human remains, homicides, and coroners' death investigations organized on a systematic data base
- systematic use of other potential linkage indicators such as composite drawings, forensic tests conducted by CFS, and profiling,
- training for major case managers and senior investigators to use all potential linkage indicators
- case management systems that heighten the awareness, of uniformed officers and investigators throughout a police force, to linkage indicators

20. A centrally supported organizational structure is required, based on co-operation among individual police forces, that combines unified leadership across police jurisdictions with organized case management procedures and inter-disciplinary support from forensic scientists and other agencies. The recommended structure is as follows:

    - two levels of co-ordination including a Board of Directors and an Executive Committee
- the Board of Directors,
- based on the CISO police co-operative model
- composed of twelve police chiefs chosen by the OACP and/or the CISO governing body, the Chief Coroner, the Director of the CFS, the Assistant Deputy Solicitor Generals for Policing Services and Public Safety
- supported by existing structures without the creation of any new bureaucratic agency or the attraction of bureaucratic baggage
- to implement the policies and maintain the framework that will ensure the smooth operation of the recommended major case management system for multi-jurisdictional investigations of serial predators
- to resolve any conflicts that cannot be resolved by the officer in charge
- to be directly accountable to the Solicitor General for all financial issues but independent in relation to police operations and investigations

- to operate on the basis of standard memoranda of agreement entered into voluntarily by all police forces in Ontario
- to be administratively supported by a small staff group similar or identical to the present CISO structure the Executive Committee
- a small group of Board members accountable to the Board of Directors
- responsible for the triggering mechanism, based on the ViCLAS definition, which launches the co-ordinated investigation in a particular case
- all abductions, homicides, sexual assaults and attempts or attempts that appear to be sadistic or sexual or predatory in nature, apparently random, motiveless or are known or suspected of being part of a series, particularly where more than one police jurisdiction is involved and where the circumstances suggest a public safety interest beyond the community or communities directly involved
- responsible for the resource decisions, financial accountability and general oversight of specific investigations, leaving the actual investigation itself to the officer in charge
- to include as ad hoc members, when dealing with a specific investigation, the chiefs or their designates of the individual forces involved and the chief of the senior officer in command, if he does not come from one of the involved forces
- responsible for selecting and, in the case of irreconcilable differences the removal, of the senior officer in charge and for major resource and policy decisions, but not to interfere with the investigative authority or accountability of the senior officer in charge
- one single senior case manager or officer clearly in charge and accountable, drawn from a cadre of approximately 12 senior and experienced criminal investigators pre-selected by the Board
- specially trained in major case management and inter-jurisdictional investigations
- accountable to the Board and the Executive Committee for financial issues and the ultimate success or failure of the investigation, but personally and directly in charge of the investigation at all times
- an inter-disciplinary Advisory Committee to ensure a consistently high level of continuing technical, legal and forensic advice; selected jointly by the Senior Case Manager and the Executive Committee, to advise the senior officer in charge but not to manage the investigation
- a support Team composed of a full-time media officer, crime analysts, profilers, computer technicians, an officer manager, clerical staff including data entry staff and a budget officer
- lead investigators for the individual cases who will have received essentially the same training package as the senior case manager

21. Standard case management procedures are required of the kind described in the Major Case Management Manual developed by the Canadian Police College, customized to the Ontario police, legal and forensic environments

22. Early approval of one single uniform computerized case management system for mandatory use in all serial predator investigations and all major sexual assault and homicide cases that could potentially fit the ViCLAS definition or the triggering definition and turn into a serial predator investigation

- with capabilities similar to the CASEFILE! system
- agreed upon quickly by the Ontario police community as the one single preferred uniform package
- updated regularly under the direction of the Board and the Executive Committee
- with its uniformity and ability to share information guaranteed by a strong prohibition against "improvements" or tinkering by individual forces that might improve it 10% and destroy 90% of its value as a common, uniform, system for information sharing
- supported by basic computer training for all investigators who will use the programme and advanced training for those at the centre of the investigation

23. Eventual standardization is desirable of other police information and record systems, information standards, and mainframes, of the kind recommended at the Fire College conference, such work not to interfere with the immediate approval of a single common computerized case management information system of the kind represented by CASEFILE!

24. Specialized training is required as one of the foundations of a new defence against serial predators, particularly in the following areas:

- Major case management and inter-jurisdictional investigation training for specially selected senior officers in command, senior investigators, and members of inter-disciplinary support teams, to include topics such as
- special problems of serial predator investigations
- special problems of inter-jurisdictional investigations
- media liaison
- victim support
- stress management
- information management

Specialized training for criminal investigators in homicide and sexual assault investigations and crime scene identification

25. An organized system is required under the direction of the proposed Board of Directors to ensure that our law enforcement agencies learn from the mistakes of the past not only in the Bernardo and other serial predator investigations but also the problems and solutions identified by Ontario coroners' juries

26. Funding and support for serial predator investigations is required under s. 9 of the Treasury Act, administered through the proposed Board of Directors and Executive committee through machinery based on the present CISO funding model. This funding cannot be used simply for the purpose of cost relief for investigations that should be funded locally.

27. Funding is required for the training packages, the establishment and maintenance of a reasonable turnaround time for DNA testing, and the start-up and maintenance of the

proposed system. The necessary funds are modest compared with the human and financial costs of failing to increase, to a more reasonable level, the systems of public protection against serial predators. It would be institutionally reckless to fail to do so.