September 03, 2016

Honourable Diana Whalen
Minister of Justice and Attorney General
Province of Nova Scotia

Dear Minister and Attorney General:

Re: Samantha Mercer Death

Please find enclosed the report on my independent external review of the above-noted case that you ordered pursuant to s. 7 of the *Police Act,* S.N.S., 2004,c.31 and s. 6 of the *Public Prosecutions Act*, S.N.S. 1990, c.21.

Thank you for the opportunity to review the investigation of the death of this child. I hope my report will serve to improve future investigations.

Sincerely,

Gerard E. Mitchell

Report of Hon. Gerard E. Mitchell

Pursuant to an order of the Honourable Diana Whalen the Attorney General and Minister of Justice for the Province of Nova Scotia authorizing him to conduct an independent external review of the Truro Police Service's handling of the investigation into the death of Samantha Mercer and two other matters related thereto.

Samantha Mercer Report

Samantha Mercer died at the IWK Hospital in Halifax, Nova Scotia, on March 3, 2005. She was just three-and-a-half years old.

I have been asked by the Attorney General and Minister of Justice of Nova Scotia to do an independent review concerning the investigation of Samantha's death by the Truro Police Service.

Chronology

Samantha's death resulted from one of a number of serious injuries she sustained in her home at 341 Brunswick Street, Truro, Nova Scotia. She lived there with her mother, Aleisha Mercer, and Aleisha's boyfriend, Terry Dean Allen. They had only been in that home for eight days when this tragedy occurred.

The injuries that led to Samantha's death occurred around 5:30 p.m. on March 1, 2005. At the time, she was in the sole care of Terry Dean Allen. Her mother had gone to work at a local call centre at around 4:00 p.m.

Mr. Allen and a couple of his friends arrived with Samantha at the Colchester Regional Hospital in Truro around 7:00 p.m. He explained to medical personnel there that she had fallen down a stairway around 5:30 p.m., but that he had not realized the seriousness of her condition until much later. Samantha was intubated at the Colchester Hospital then quickly transferred by ambulance from there to the IWK Health Centre in Halifax, where she died of her injuries two days later. After she died a number of her organs were donated so that others could live.

Medical examinations found Samantha had fifty-seven bruises on her body. Only a few of them pre-dated the evening of March 1, 2005. She also had a fractured left arm and a number of compressed vertebrae. Her death was caused by severe trauma to the top of her head.

At about 11:00 p.m. on March 1, 2005, Bible Hill RCMP received a complaint from a social worker from a child protection agency about a possible child abuse incident involving Samantha Mercer. Some of the information given to the RCMP led them to believe that the incident had occurred at the home of the child's grandmother, Shannon Mercer, in North River, Nova Scotia. However, they soon realized that the incident actually took place at 341 Brunswick Street, which is within the town of Truro. Therefore, in the early hours of March 2, 2005, the RCMP turned the investigation over to the Truro Police Service.

At about 1:00 a.m. on March 2, 2005, Truro Police sent an officer to secure the area around 341 Brunswick Street and to keep anyone from entering the home. Neither that officer nor the one who replaced him later entered the home.

When Samantha was taken to hospital, two dogs were left at the scene to roam the house at will. At least three people, including Mr. Allen, had accessed the scene after Samantha was taken to hospital and before the Truro police arrived at the scene or even knew about the incident.

While the area around the scene was being guarded, two senior Truro Police officers went to the IWK, arriving there at around 5:50 a.m. on March 2, 2005. These officers spoke with hospital staff, saw Samantha, and took a statement from her mother, Aleisha. They also got Aleisha to sign medical release forms and a consent for them to search the

residence. She was the sole named lessee of 341 Brunswick Street, although she and Samantha had been living there with Mr. Allen.

Although police had been watching outside the home since 1:00 a.m. on March 2, 2005, they did not enter it until around noon. Meanwhile, Mr. Allen's dog was still in the house. The other dog that had been in the home had been taken out before police arrived to secure the scene.

The police investigation of 341 Brunswick Street began around noon on March 2, 2005. Just before they entered the home to begin their investigation, a female with a key entered it to retrieve Mr. Allen's Rottweiler. This dog was upstairs when the person retrieving him entered the house.

Once inside, the police examined the scene, took photographs, made measurements, and seized various items that they later sent to forensic laboratories for testing. That same day the police also interviewed and took a statement from Mr. Allen.

The police did not obtain a warrant to search the home, and they did not advise Mr. Allen of his constitutional rights prior to taking the statement from him. [Mr. Allen later gave four additional statements to police. In each of those cases he was advised of his constitutional rights. All five of his statements were exculpatory.]

As a result of their investigation over a few days, the police came to believe that Samantha's death was caused by assaultive behavior on the part of Mr. Allen. He was arrested and charged with manslaughter under s. 236(b) of the *Criminal Code* on March 16, 2005.

Mr. Allen was remanded in custody until March 21, 2005. On that day, he was released on a number of conditions.

On July 20, 2005, Mr. Allen appeared in court and elected to be tried by a judge and jury.

A preliminary inquiry began on December 14, 2005, but did not finish until July 20, 2007. The Crown sought to have the Mr. Allen committed for trial on an upgraded charge of second-degree murder. However, the preliminary inquiry judge decided to commit him to stand trial only on the charge of manslaughter.

Mr. Allen subsequently changed lawyers, and, on August 11, 2008, he re-elected to be tried before a Provincial Court Judge.

The trial in Provincial Court began on June 15, 2009, and ended on June 29, 2009.

The Crown's case was circumstantial. The theory was that Mr. Allen violently assaulted Samantha and caused her death by slamming her headfirst into a gyproc wall. The defense claimed Samantha's head injury, and some of her other injuries, resulted from an accidental fall down the stairway that connected the first and second storeys of the home. The defense also claimed that a circular bruise on Samantha's back was the result of accidently being hit by a small plastic soccer ball.

At the trial the Crown called several laypersons, one police officer, and five medical experts as witnesses. The defense called Mr. Allen himself and a biomedical engineer. The latter was qualified to give opinion evidence in relation to the mechanism of injury to the human body and

the calculation of physical forces capable of producing certain kinds of injury. He opined that a child tumbling down a stairway could possibly result in a serious head injury such as the one Samantha had.

During the trial there were no *Charter* applications to exclude evidence or to stay proceedings. There were no issues over late disclosure or non-disclosure. There were no issues over the continuity of the exhibits tendered. Furthermore, there was agreement among counsel that the statements Mr. Allen gave to authorities could be used for the purpose of cross-examination.

On September 14, 2009, the trial judge rendered a lengthy decision in which he concluded [para. 232] by saying:

> The sudden and unexpected death of a child is a devastating event. Samantha's death is such a case. It is particularly difficult when the circumstances are not easily understood because of the multiplicity of the bruises, the presence of other injuries and the rarity of a fatal impact from a stairway fall. In the end there may never be any clear answer as to precisely what occurred. The evidence supports more than one explanation. My duty and responsibility is to determine whether it has been proven beyond a reasonable doubt that Terry Dean Allen caused the death of Samantha Mercer by an unlawful act; that is, an act which was objectively dangerous. In my judgment the Crown has not met that burden. Accordingly the accused is found not guilty and he is acquitted.

It should be noted that the trial judge's state of reasonable doubt was partially based on the opinion of the biomedical engineer and on the fact that even some Crown experts had admitted during their testimony that Samantha's injuries could possibly have been caused in the manner Mr. Allen described.

The Crown filed a Notice of Appeal on October 16, 2009. However, the appeal was abandoned on February 11, 2010, after Crown appellate counsel concluded it had no reasonable chance of success.

On March 4, 2015, long after the trial and abandonment of the appeal, Shannon Mercer, Samantha's grandmother, submitted a complaint to the office of the Nova Scotia Police Complaints Commissioner alleging that the Truro Police Service did not do an adequate investigation into Samantha's death.

On March 13, 2015, the Nova Scotia Police Complaints Commissioner advised Shannon Mercer that the complaint could not be dealt with because it was filed beyond the six-month limitation period provided for under the *Police Act Regulations* made pursuant s. 97(1) of the *Police Act*, S.N.S., 2004, c. 31.

On March 28, 2015, Shannon Mercer wrote to Premier McNeil requesting that he look into the investigation by the Truro Police Service of her granddaughter Samantha's death.

On May 8, 2015, Premier McNeil wrote to Shannon Mercer acknowledging receipt of her letter. He informed Ms. Mercer that he had referred her correspondence to the Minister of Justice for review by appropriate staff.

On July 20, 2015, the Minister received a letter from Shannon Mercer outlining her complaints about the investigation by the Truro Police Service of Samantha's death. Her complaints related to the gathering of evidence and protection of the scene.

On November 10, 2015, the Nova Scotia Minister of Justice wrote Shannon Mercer informing her that senior staff of her department had re-examined the case over the previous several months and they had determined that Truro Police Service was not responsible for the verdict in the case against Mr. Allen. The Minister added that according to the assessment of officials on her staff, Truro Police Service "currently" have appropriate training and expertise to undertake investigations in major crimes.

On March 30, 2016, Shannon Mercer responded to the Minister saying that she was more concerned about the capabilities of the Truro Police in 2005 than about their capabilities in 2015. She asked the Minister to send her copies of any documents generated by her department in the course of the assessment of the capabilities of the Truro Police from March 1, 2005, onward.

On April 7, 2016, Department of Justice officials obtained information, new to them, from the Public Prosecution Service about an internal disciplinary proceeding within the Truro Police Service that, in part, related to the conduct of the investigation into Samantha's death.

The information about the disciplinary proceeding came from the Truro Police Service files and was released to the Crown sometime after March 20, 2009, for disclosure to the defense pursuant to the ruling of the Supreme Court of Canada on January 16, 2009, in the case of *R. v. McNeil*, 2009 SCC 3.

Upon receiving the information about the disciplinary proceedings in April of 2016, the Minister of Justice ordered an independent external review of the investigation of Samantha Mercer's death by the Truro

Police Service. On May 11, 2016, the Minister wrote to Shannon Mercer informing her that I had agreed to undertake this independent external review.

Terms of Reference

The Review was ordered by the Minister pursuant to section 7 of the *Police Act*, S.N.S., 2004, c. 31 and section 6 of the *Public Prosecutions Act*, S.N.S., 1990, c. 21.

The terms of reference for the review the Minister provided required me to consider and evaluate the investigation into the death of Samantha Mercer by the Truro Police Service, the interactions/communications between the police and the Public Prosecution Service in the prosecution relating to Samantha's death, and the subsequent internal review of the matter by the Department of Justice.

The terms of reference also required me to provide answers to the following questions:

1. Was the investigation in the death of Samantha Mercer appropriately handled by the Truro Police Service? If not, why not? Are there any recommendations for the Truro Police Service to improve their investigation into major crimes?

2. Was the internal review of the Mercer matter conducted by the Department of Justice appropriately handled? If not, why not? Are there any recommendations to make with respect to best practices the

Department of Justice should adopt in conducting internal reviews of policing agencies?

3. Did the interactions/communications between the Truro Police and the Public Prosecution Service in the prosecution for the Samantha Mercer death follow best practices? If not, are there any recommendations as to how the Truro Police and the Public Prosecution Service could improve their processes and procedures in such cases in the future?

My findings and any recommendations were to be reported to the Nova Scotia Attorney General and Minister of Justice by August 31, 2016.

The terms of reference for the report direct me to respect personal privacy concerns. Accordingly, I have not named any individuals involved in the case other than Mr. Allen, Aleisha Mercer, and Shannon Mercer.

I have also been mindful that the terms of reference require me to respect the principle of prosecutorial independence.

The Review Process

The review process included the following:

1. Examining documents including correspondence, transcripts, and exhibits relating to Samantha's case obtained from by the Nova Scotia Department of Justice, the Nova Scotia Public Prosecution Service, the Truro Police Service, and the Mercer family.

2. In-person meetings with the following:

* Three members of the Mercer family and their lawyer, Brian F. Bailey;

* Three members or former members of the Truro Police Service;

* Three members or former members of the Nova Scotia Public Prosecution Service; and

* Two members or former members of the Nova Scotia Department of Justice.

3. Numerous telephone conversations and/or email exchanges with various personnel of the Nova Scotia Department of Justice, the Public Prosecution Service of Nova Scotia, and the Truro Police Service.

4. A visit to the house located at 341 Brunswick Street in Truro.

Everyone I dealt with during the review process was very cooperative. However, memories have faded over the past eleven years.

Issues with the Police Investigation

As a result of my review, I have come to the conclusion that the Truro Police Service did not handle the investigation well. Their investigation was marred by procedural errors, neglect, lack of diligence, and failure to provide the Crown with appropriate deliverables in a timely manner.

As well, in some cases they failed to do appropriate follow-up interviews.

Although several of the officers involved had taken courses on dealing with major cases, the investigation lacked the leadership, teamwork, organization, and supervision that are the hallmarks of proper major case management.

The Samantha Mercer case was very complex. She had many serious injuries. Numerous medical personnel were involved. There were issues surrounding the mechanisms of her various injuries, especially the fatal one to the top of her head. There was contamination of the scene. There was no known eyewitness other than Mr. Allen. This was clearly a major case that required a very careful, methodical, and painstaking investigative approach.

The Truro Police did not take that kind of approach. Instead, they began their investigation by exposing their evidence gathering process to constitutional challenge by taking unnecessary shortcuts. On March 2, 2005, they searched the suspect's home and seized items from it without a warrant, and they took a statement from him without advising him of his rights to counsel. Over the course of time the Crown had many concerns about these and other matters relating to the investigation.

Crown Complaints and Internal Discipline

From shortly after the charge was laid on March 16, 2005, until May of 2006 there was a fairly steady stream of letters from various Crown Counsel to Truro Police investigators identifying problems and expressing concerns about the Police's manner of investigation and their

management of the file. The next several paragraphs contain examples of some of the problems the Crown had with the investigation.

A letter, dated March 18, 2005, complained about the undecipherable state of the file and that the police had laid the charge against Mr. Allen prematurely when the investigation was not sufficiently complete.

On May 12, 2005, nearly two months after the charge was laid, the Crown wrote the police asking, "what exactly is the investigation theory as to how Mr. Allen caused Samantha's injuries ? "

On November 7, 2005, Crown counsel wrote to one of the investigators complaining that specific materials requested on April 6, August 19, September 20, September 21, and September 28, 2005, remained outstanding. It was also noted that only one of the investigators had been supplying the Crown with their updated notes and activity reports.

Another example of the Crown's continuing frustration with the investigation was addressed in a letter dated November 18, 2005. This involved a senior investigator possibly failing to arrange or attend a meeting with Crown Counsel and an important witness because the investigator was going to Halifax to serve subpoenas. The Crown Counsel pointed out that senior officers should give priority to meeting with the witness and that junior officers could serve the subpoenas.

The problems with the investigation came to a head when many of the Crown's concerns were summarized in a lengthy letter from a Senior Crown Counsel for the Central Region of Nova Scotia to the then Deputy Chief of the Truro Police Service. The letter is dated May 3, 2006, and states in part the following:

Pursuant to your request the following is a list of concerns regarding the investigation of the death of Samantha Mercer. Two basic problems have emerged in this file. The first is that the investigation was not completed prior to the laying of the charge. Secondly, there is a lack of understanding of the role of the police investigators and the role of the Crown in our criminal justice system. Following is a list of particular problems in relation to the above noted matter.

1. The failure to understand and appreciate the need for a search warrant prior to entering the house at 341 Brunswick Street. This is a basic requirement of our Constitution.

   The consent of one of the adults living in the residence may be sufficient. It may not be sufficient. Regardless of the outcome of this issue, the Crown, the Defence and the Court will have to allocate a great amount of time and money litigating the matter.

   In the event the Courts find the search unconstitutional and the evidence obtained in the search ruled inadmissible, the trier of fact will be deprived of important evidence. Particularly the evidence of the dent in the child's bedroom with her hair embedded in the dent will not be admissible. This is a crucial piece of evidence.

2. The failure to read Mr. Allen his Constitutional Rights prior to the March 2/05 interview. This again is a basic requirement in our criminal justice system. The Crown will have to allocate considerable resources researching the admissibility of this statement.

3. The failure to interview and obtain statements from all the medical personnel who provided assistance to Samantha Mercer.

   [Two doctors] were the only medical personnel interviewed. Their opinions are important but they are not the entire medical case.

4. In addition to [the two doctors interviewed] the following medical personnel should have been interviewed and notes of interview or statements obtained: [The Crown Counsel then lists 11 names of individuals or groups who should have been interviewed.]

5. Initially the medical records were obtained by a consent document. It would have been preferable to obtain these documents with a search warrant.

6. There was a failure to obtain all the medical records with the initial consent document. No diagnostic images were obtained in the original seizure. The investigators were not aware of the existence of the diagnostic images.

7. The medical records were not presented to the Crown in any organized way. There was no analysis of these records as to their meaning and relevance. The documents were simply handed over to the Crown.

   Mr. ------- [another Crown Counsel], in a letter of August 22, 2005 to [one of the investigators] made the following comments:

   > "With respect to the hospital records provided from Colchester Regional and Halifax, no analysis has been provided. The documents are not always self-explanatory nor is authorship. For example, it is not always clear who made what observations as to the condition of Samantha's body (in particular with respect to bruises) and when. Please interview and obtain statements from the people involved, so that we can make a better assessment as to who will be required for the preliminary."

   The Crown has never been provided with the above-requested information. When the Crown is not provided the complete file in a timely fashion it becomes difficult to comply with disclosure requirements and to properly prepare for Preliminary Hearings and Trials.

8. The investigators failed to recognize the complexity of the medical evidence and consequently failed to interview many medical witnesses or to understand the medical documents.

9. In addition to medical records a number of Social Workers and Nurses were involved with Mr. Allen and Ms. Alicia [Aleisha] Mercer. The medical files contained notes of these individuals. There [appear] to be no interviews with these people. We do not have any statements [from] these people. In particular we do not have an interview with [one named social worker and one named nurse].

10. The Crown requested statements from the Ambulance attendants who transported Samantha Mercer from the Truro Hospital to the IWK Hospital, we have not yet

received these statements. These statements are necessary to determine if Samantha Mercer was injured in any way while being transported to Halifax. This is unlikely but in a criminal prosecution this type of detail must be investigated and accurately documented.

11. In addition the Crown had requested the investigators to locate an expert on falls down stairs. To date the investigators have not located or identified to us an expert in this field.

12. The Crown retained an expert in relation to the force required to put a dent in gyproc equivalent to the dent in the child's bedroom at 341 Brunswick. The investigators basically left this part of the investigation to the Crown Attorney's office. In addition the Crown had requested the investigators to locate an expert in strength and characteristics of gyproc. I was advised that one could not be located.

13. In addition you are aware of the problems obtaining the search warrant for the large piece of gyproc and the failure to secure and tag this evidence.

14. The additional important factor in not obtaining and understanding the complete file prior to laying a charge is that once the charge is laid the *Charter* right to a trial within a reasonable time becomes an important factor in the litigation. All delays in obtaining additional evidence risk *Charter* challenge.

In addition to the above I would also refer back to my April 7, 2006 letter to you in which I referred to the information I was being provided by the investigator that he had no police vehicle and no phone. In addition I was advised that the investigator had a number of other important files that he was working on and did not have enough time to follow through on a number of the issued [issues] raised in the Terry D. Allen matter.

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Following this letter, the Truro Police Chief initiated internal disciplinary proceedings against the investigator referred to in the last paragraph set out above.

The Chief alleged that the investigator had neglected his duties in regard to the investigation of the death of Samantha Mercer.

The chief of another municipal police department was appointed to investigate the complaint. He concluded: "It is abundantly clear that the allegation of neglect ... is substantiated."

On December 18, 2006, the accused investigator was found guilty of neglecting, without adequate reason, to promptly, properly, or diligently perform his duties as a member of the Truro Police Service in relation to the investigation of the death of Samantha Mercer, as well as some other important cases that were ongoing at the time, contrary to section 24(3) of the *Police Act Regulations*.

As penalty, the investigator was demoted and required to attend a major case management course as soon as possible.

The investigator filed an appeal with the Nova Scotia Police Review Board but subsequently withdrew it.

As a result of my review of the correspondence and materials I have been referring to, it is clear to me that the Truro Police Service mismanaged the investigation into the death of Samantha Mercer. My conclusion is further fortified by Police's incomplete followup on the issue of a possible missing witness which I will address in the next section of this report.

Possible Missing Witness

The Truro police at one time believed there might have been another person at the scene around the time of Samantha's injuries were sustained. If so, that person would have been important to interview.

At the preliminary inquiry one of the investigators admitted that police had approached a number of people requesting that they provide DNA samples. A request for analysis from Truro Police to the Halifax Forensic Laboratory on March 16, 2005, states in part:

> The mother of the victim states she made her bed prior to going to work. When she left the master bedroom the room was immaculate. When investigators arrived her bed was in disarray and candles were on the floor. The mother states the candles were not there when she left. Investigators believe the suspect had another person in the bed the evening of the homicide.

The items sent for analysis included a bloodstained cutting from the mattress in the master bedroom, a blood sample from Samantha Mercer, and buccal samples from Aleisha Mercer and three other females of interest. The police also sent for analysis two swabs of suspected blood from the top of the basement stairs

The analysis of the bloodstain on the mattress revealed that it contained female DNA from an unknown female. It did not match the DNA of Samantha Mercer, her mother, or any of the other females from whom the police had obtained buccal samples. No human DNA was detected in the swabs of suspected blood taken from the top of the basement stairs.

The police files also contain statements from two persons that should have led them to interview at least two other females, but there is no

indication that they did. The police files do indicate that on March 14, 2005, they checked with one taxi company to see whether any female person had been driven to or from 341 Brunswick Street between 4:00 p.m. and 6:00 p.m. on March 1, 2005. The response was negative.

On September 28, 2005, a Crown Counsel wrote to one of the investigators asking that he follow up on the interview with Aleisha Mercer that had taken place in early March. He was asked in particular to make inquiries regarding the state of the master bedroom and where the dog was kept when they were not at home. The Crown Counsel also wanted to know whether investigators had addressed Ms. Mercer's comments raising the possibility of someone else being in the home.

None of the police or former police officers that I spoke to about the investigation had any recollection of ever having entertained the "missing witness theory" in the first place. There is no record of what, if anything, the police did to evaluate or follow up on the leads or tips they received relative to the theory. There may have been a point when there was good reason to abandon this line of investigation, but there is nothing in the files that indicates when or why it was discontinued.

One officer I spoke with suggested that the bloodstain on the mattress likely pre-dated March 1, 2005. The officer thought it was significant that the stain was only on the mattress and not on the sheets. The mattress was not new and had been brought to the home by Mr. Allen.

Truro Police Service Today

Although there were serious deficiencies in the capacity of the Truro Police Service of the 2005 era to deal with major cases, I do not find that to be the case today. I say that primarily because in 2013 the Truro Police Service entered into a memorandum of understanding with the RCMP, whereby a Truro investigator is seconded to the RCMP Northeast Nova Major Crime section, which will in turn provide a major crime coordinated investigation team to respond to major crimes in the jurisdiction of the Truro Police Service.

This arrangement with the RCMP provides the Truro Police Service with a ready coordinated investigation team with access to a number of officers experienced in the investigations and management of major crimes. Another benefit of this arrangement is that the Truro Police Service investigator embedded with the Northeast Nova Major Crime Section will acquire training and experience in major crimes investigation that at the end of the secondment he or she can bring back and share with fellow officers of the Truro Police Service.

In addition to the arrangement with the RCMP Truro Police Chief advises:

> Our criminal investigators in major crime receive training at the Canadian Police College in Ottawa in major crime investigative techniques and the supervisor would have the major crime management course. They also receive training from the Nova Scotia Medical Examiner's office, and attend other training opportunities at the Atlantic Police Academy or from other police agencies.

I note, too, that a practice has been adopted that all Crown Counsel correspondence with Truro police officers is copied to a designated

senior officer to ensure that the request or matter of concern is acted upon and does not become lost or forgotten. This also provides a central record of all correspondence from the Crown.

Along with the measures already taken I recommend that the Department of Justice conduct regular audits of all police services similar to those in Truro to ensure that training, investigations, file management, and information sharing meet appropriate standards. As well the audit should ensure the police service has a set of standard operating procedures in place for officers to follow and there is compliance with any ministerial directives that have been issued pursuant to the *Police Act*.

Many small local police agencies would have great difficulty in dealing with major cases. Police in small agencies may have undergone some training in major case investigation and/or management, but they have little occasion to use or enhance these skills in the field because major crimes are rare in the communities they serve.

I would therefore recommend that Nova Scotia consider establishing a major case support unit that would be ready to assist any small municipal police department investigating a major crime if it does not already have an arrangement with the RCMP similar to the one the Truro Police Service now has in place.

The Internal Investigation by Department of Justice Staff

As a result of concerns expressed by the Mercer family about the quality of the Truro Police investigation of Samantha's death, the Department of Justice did a review of the case in the autumn of 2015. The review

included several meetings with the Mercer family, an examination of the trial judge's decision, and conversations with people in the Medical Examiner's office and the Public Prosecution Service. According to an internal briefing note the representatives of the Public Prosecution Service and the Medical Examiner's office who spoke with Departmental staff indicated that, even if correct, the concerns raised by the Mercer Family would not have impacted the outcome of the trial.

On November 10, 2015, the Minister wrote to Samantha's grandmother, Shannon Mercer, saying:

> At your request, we have had this case re-examined by senior staff over the past several months. They did not determine that the actions of the Truro police were responsible for the court's finding.

However, this re-examination did not have the advantage of having the complete files from the Truro Police Service or the Public Prosecution Service.

In order to allow Departmental staff to conduct a deeper assessment of the Truro Police investigation than they did, the Minister would have had to make an authorizing order under section 7 of the *Police Act* similar to the one I received. There was no such order issued.

If an order had been made directing members of the Department staff conduct a section 7 investigation, they would have obtained complete files from the same sources as I did. If they had done so, they would have known much earlier than April of 2016 about the Crown's problems and concerns with the investigation and about the disciplinary matter.

Communications between Crown and Police

The Crown complained early and often to the Truro Police about various concerns and problems with their investigation. I counted about 15 letters in that vein between March 18, 2005, and May 2006. These letters were clear and advised police what the problems were and what needed to be done.

When the Crown did not get appropriate responses from investigators, they asked the Deputy Chief for his assistance. That was the appropriate way for the Crown to proceed. The next step would have been for the Director of the Public Prosecution Service to call the Truro Chief of Police and ask for him to become engaged.

Fortunately, as a result of the persistent prodding from Crown Counsel, the police eventually provided sufficient evidence to get through the preliminary inquiry and go to trial with a reasonable prospect of obtaining a conviction.

As mentioned earlier, the practice that has now been adopted of copying all correspondence to Truro police officers to a designated senior officer should help ensure Crown requests and concerns get the attention they require.

Conclusions

1. The Truro Police did not properly handle the investigation of the death of Samantha Mercer because they did not take a proper major case management approach.

2. The Truro Police Service of the present day has the capacity to properly conduct major investigations.

3. The Internal Review conducted by the Department of Justice should have been pursuant to an order under section 7 of the *Police Act*.

4. The interactions/communications between the Truro Police Service and the Public Prosecution Service were handled properly by the latter. Prosecutors followed appropriate channels and were clear in expressing their concerns and needs. However, the Truro Police Service was not as responsive as it should have been. A better system of handling correspondence between the Crown and Truro Police is now in place. This new system should help ensure the Truro Police Service will respond to Crown requests and concerns in a timely manner.

Recommendations

1. That the Department of Justice conduct regular audits of the Truro Police Service and all other municipal police services to ensure they are maintaining the appropriate professional standards required for adequate and effective policing.

2. That the Department of Justice take measures to ensure small municipal police services have ready access to well qualified and trained support and assistance in the investigation of major cases that may only occur once in a while in their jurisdictions.

3. That as soon as practical, investigators of a major crime should seek legal advice and assistance, but not direction, from a Crown counsel.

4. That whenever Department of Justice staff undertakes a review of a police investigation they be armed with a ministerial order under section 7 of the *Police Act*.

Closing Remarks

The tragic death of Samantha Mercer deserved a thorough investigation, especially due to the suspicious circumstances surrounding how her many severe injuries occurred. Given the new information she received in April 2016, the Minister was right to revisit the matter and order this review of the Truro Police Service's investigation. I hope my review helps ensure better investigations of such major cases in the future.

Respectfully Submitted to The Honorable Diana Whalen, Attorney General and Minister of Justice for the Province of Nova Scotia, this 3rd Day of September, 2016.

Gerard E. Mitchell