OFFICE OF THE INDEPENDENT POLICE REVIEW DIRECTOR

Investigative Report

Complainant(s):	Brad DeBUNGEE Jim LEONARD
Complaint Number(s):	E-20160318114837984 3 E-20160318111703781 2
Police Service:	Thunder Bay Police Service
Director:	Gerry McNeilly
Date:	February 15, 2018

Summary of the Complaint

On October 19, 2015, at approximately 9:30 a.m., the body of an unidentified Indigenous male was found in Thunder Bay's McIntyre River. A passerby spotted the body in the river in the area of Carrick Street and Waterford Street and called 911.

The Thunder Bay Police Service (TBPS) attended the scene. At approximately 12:45 p.m., three hours after the discovery of the body, the service issued a press release that stated, *"An initial investigation does not indicate a suspicious death. A post-mortem examination will be conducted to determine an exact cause of death. The male is still to be positively identified."*

TBPS issued a subsequent press release approximately 25 hours after the discovery of the body. In the release, TBPS identified the deceased male as Stacy DeBungee (SD) and stated that his death was deemed *"non-criminal."*

On October 21, 2015, Complainant 1, the deceased's brother, Civilian Witness 6 and their aunt attended TBPS to request information about what happened to their family member SD and obtain answers about how he came to be in the river.

They spoke to three officers identified as [redacted] and [redacted]. The officers told the family that SD's death was not classified as foul play and that further information would be provided by the Coroner.

When pressed with further questions, [redacted] informed the family of a theory that SD had passed out unconscious, simply rolled nine to 10 feet down the riverbank into the river and drowned.

Complainant 1 and Complainant 2 believed that the investigating officers concluded that SD's death was an accident prior to taking any meaningful investigative steps to determine the cause of death and how SD ended up in the river. As a result of their lack of confidence in the investigation, they hired Investigative Solutions Network Inc. (ISN), a private investigations company, to investigate the death.

The ISN investigation traced the steps of SD the evening prior to his death. The investigation revealed that on October 18, 2015, SD left his home in Thunder Bay to meet with his common law wife's niece. He did not return home that evening.

The ISN investigation further revealed that SD was in the company of several individuals and they went to the LCBO before going to a spot near the location where his body was subsequently discovered. The ISN investigation determined that those individuals were among the last ones to see SD. Up to that point none of those individuals had been interviewed by TBPS. Shortly after the death two of the individuals moved to Kenora, Ontario.

The ISN investigation identified a concern that TBPS made the determination of *"no foul play"* and the death being *"non-criminal,"* prior to the autopsy being conducted and in the absence of information from any potential witnesses.

According to Complainant 1 and Complainant 2, the TBPS investigators used a *"very simple, unsophisticated, unscientific method"* of determining how SD ended up in the river. They believed that the TBPS investigators' assessment at the crime scene, and their conclusion that SD rolled into the river and drowned, was entirely speculative and not based on evidence.

They further maintained that TBPS made an assumption that because SD was Indigenous, intoxicated and reportedly sleeping along the riverbank, the only way he could have ended up in the river was by simply rolling over in his sleep.

This complaint stems from the Complainants' lack of confidence in the TBPS investigators' rushed conclusion of what happened to SD. They believed that the investigation was inadequate and relied, among other things, upon the deficiencies identified in the ISN Investigation report.

This report will examine the TBPS investigation into the death of SD to determine whether reasonable and probable grounds exist that any officers involved in the investigation engaged in professional misconduct.

Notes:

1. **For the purposes of this report, the OIPRD used the term Indigenous. In interviews, witnesses and Respondent Officers used different terminology to describe a person's identity. Where the terminology varied from the term Indigenous, this report reproduced the term used by that individual.**

2. **Officers are referred to by their rank at the material time, although their ranks, in a number of instances, have subsequently changed.**

Code of Conduct Allegations

The allegations of misconduct pursuant to the *Code of Conduct Schedule* of Ontario Regulation 268/10 under the *Police Services Act* (PBB) include:

Neglect of Duty

2(1)(c)(i) Any chief of police or other police officer commits misconduct if he or she without lawful excuse, neglects or omits promptly and diligently to perform a duty as a member of the police force of which the officer is a member, if the officer is a member of an Ontario police force as defined in the Interprovincial Policing Act, 2009.

Discreditable Conduct

2(1)(a)(i) Any chief of police or other police officer commits misconduct if he or she engages in Discreditable Conduct, in that he or she, fails to treat or protect persons equally without discrimination with respect to police services because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability.

Summary of Statements – Witnesses (Civilian and Police)

Complainant 1

Complainant 1 provided a *recorded interview with the OIPRD on December 2, 2016. The following is a summary of the relevant portions of the interview.*

Complainant 1 is the elder brother of SD, the deceased. The Complainant described SD as a *"happy-go-lucky guy who was always in a jolly mood."* He stated, *"He was like a comedian and made people laugh, a friendly guy. He'd talk to you on the street or whatever – a storyteller."*

Complainant 1 said that he was very close with SD and they would often talk about personal things. He met SD's common-law wife, Civilian Witness 4, and her daughter, Civilian Witness 5, approximately three years prior. He said that SD and his wife had a *"normal"* relationship and were not too *"rambunctious,"* and did not go into *"overkill"* when the party started. He said they were not partiers, but they did drink. Complainant 1 did not know if they drank on a daily basis, but whenever he would go to see them, they would have some beer or wine.

According to Complainant 1, SD had dealings with TBPS on numerous occasions. He said that sometimes SD would be out panhandling and the police would approach him and say that he was intoxicated in a public place. He would be arrested, spend the night in jail and be released the following day. He said that was the extent of SD's interactions with the police.

Complainant 1 said that he was not familiar with any of the people who were reportedly with SD the night prior to his death. His nephew had mentioned one of the people and he thought she was *"shady"* and might have been a member of a gang.

Complainant 1 was living in Quebec when he learned of SD's passing. His ex-partner called him and informed him that his brother's body was found in the river. She told him that she had received a message from Civilian Witness 6, his cousin, who, in turn, had heard about what happened from a friend. Complainant 1 said that he was very distraught when he heard about his brother's death.

On October 20, 2015, he attended TBPS with Civilian Witness 6 and their aunt to get information about SD's death. They initially spoke to [redacted] who requested that they return the following day as he was busy at that time.

On October 21, 2015, Complainant 1, Civilian Witness 6, and their aunt returned to TBPS to get any information they had pertaining to SD's death. Complainant 1 indicated that [redacted] and [redacted] and [redacted] were present.

[redacted] informed them that a passerby walking his dog by the river saw a body in the water and called police. He further informed them that he was one of the officers that retrieved SD's body out of the water. The officers advised that they had attended the scene and had taken pictures of the area. They believed that SD had fallen in the water and that hypothermia was the cause of death. They stated that because of the coldness of the water he would not have been able to survive for very long.

The Complainant asked the officers a series of questions about how SD was discovered in the river. He asked if his body was face down or face up. He asked how fast the water was flowing and how far upstream SD was found. He wanted to know the speed of the current to determine if it could have dragged SD under and whether the strength of it kept him submerged. He said that [redacted] indicated that they could not tell at that point the flow of the water, but he did not believe that the current dragged SD under the water.

[redacted] explained that SD was with another individual and they both had been *"passed out"* on the bank of the river. He indicated that someone saw them there at approximately 7:30 p.m., on October 18, 2015.

[redacted] further informed him that they found SD's identification in a plastic bag on his person and identification they believed belonged to the other individual on the river bank. Complainant 1 asked if they had interviewed that person and [redacted] said that they had not. [redacted] indicated that the individual did not want to be found because he had several outstanding warrants. When Complainant 1 asked who the individual was, [redacted] said he could not divulge that information.

The police told Complainant 1 that they believed that SD may have passed out and rolled down the bank into the river and drowned. Complainant 1 found the explanation difficult to accept. He informed the officers that he was aware that at least seven people had previously been found deceased in the river and there were no investigations by TBPS into what happened. He said it appeared to be an ongoing thing. None of the officers responded to his remarks.

Complainant 1 advised the officers that he was thinking of getting legal representation to look into the matter. He said it was at that point that [redacted] became defensive and started saying, *"No, no, no!"*

Complainant 1 asked if he could view SD's body. He was informed by [redacted] that he would have to wait until the Coroner released the body.

Complainant 1 said that the other two officers remained quiet and may have said a couple of things, but he could not recall who said what.

He indicated that during the meeting, one of the officers mentioned that they had taken pictures of the scene. When he asked to see the pictures, he was told that there were no pictures. Complainant 1 thought it was mandatory to take pictures so he confronted the officer about his duplicity. He accused the officer of being a *"liar"* and not being straight forward with him. Complainant 1 believed the officers were hiding things from him in an effort to divert his attention from what the investigation involved.

Complainant 1 stated that after he voiced his opinion, [redacted] *"looked as though he was going to get up and go after him."* He said [redacted] made a sudden movement, but he was ready and prepared to defend himself if necessary.

At the conclusion of the meeting, Complainant 1 said he extended his hand to [redacted] and thanked him for his time and effort. He said [redacted] would not shake his hand. Complainant 1 continued to hold his hand out and [redacted] reluctantly shook his hand. [redacted] then told him to call if he had any further questions.

Following the meeting, Complainant 1 and his family attended the area where SD was found. After approximately five minutes of being at the location, [redacted] arrived and told them that he would show them where SD was discovered. Complainant 1 found it strange that [redacted] happened to show up at the location the same time that they were there.

Complainant 1 explained that the reason he went to the location where SD was found was in keeping with their tradition. A marker that indicated where SD was found was also placed in the water.

[redacted] showed them the location where SD was thought to have rolled into the river. The bank appeared to be much higher than the water and was angled on a decline into the river. Complainant 1 believed that if SD had passed out and subsequently rolled into the river, there would be evidence that the grass and weeds were trampled. He did not observe that the grass leading into the river was trampled down, but there was some indentation near the location in the water where [redacted] said the body was found. Complainant 1 said that he did not observe any evidence that indicated SD had rolled into the river.

Complainant 1 was advised by [redacted] that the Coroner was going to conduct an autopsy on October 22, 2015, and he would need to talk to the Coroner directly if he had any further questions.

On October 22, 2015 at approximately 9:30 a.m., Complainant 1 called the Coroner. He was told that the Coroner was unavailable at that time and would return his call. He received a return phone call from the Coroner at approximately 2:00 p.m., that day. The Coroner informed him that he did not have the full report, but his preliminary finding for the cause of death was drowning.

Complainant 1 asked the Coroner if there was a procedure to determine body temperature to confirm how long SD was in the water. The Coroner told him that performing an autopsy was not like on television and that they did not have all of the *"complicated gadgetry to check things out."* Complainant 1 said that he *"kind of went off the deep end"* and stated, *"Well if you can't pinpoint or you have no idea what you're doing then maybe you should find a different profession."*

Complainant 1 asked the Coroner if there was some way that he could obtain a second opinion from a different Coroner and how much it would cost. The Coroner responded, *"No, you can't do that. I'm the only Coroner in this area from here to the Manitoba border and as far east as Timmins."*

On October 25, 2015, Complainant 1 attended the TBPS with Civilian Witness 7, a former homicide investigator with the Toronto Police Service. They wanted to speak to [redacted] and relay some information that they thought would be beneficial to the investigation. Complainant 1 said that they were initially told that [redacted] was not on duty. They were then told that he was not available, but would contact Complainant 1 when he became available. According to Complainant 1, he was never contacted by [redacted] and had no further discussions with him about the investigation.

Complainant 1 said that due to the lack of information from TBPS he filed a Freedom of Information (FOI) request on the grounds of *'compassionate circumstances.'* He received a denial letter that stated the investigation was ongoing and no information would be released at that time.

After he received the letter, Complainant 1 questioned why the investigation was ongoing if they had already concluded that SD's death was an accidental drowning. He wondered if the police were keeping the case open so they did not have to do further investigation or provide information to the family.

Complainant 1 said that he had a lot of negativity about TBPS and the investigation into his brother's death.

Complainant 2

Complainant 2 provided a recorded interview with the OIPRD on January 12, 2017. Present during the interview were Rainy River First Nations Council members Sonny McGinnis and Gary Medicine. Also present was Counsel for Rainy River First Nations, Julian Falconer and Meaghan Daniel. The following is a summary of the relevant portions of the interview.

Complainant 2 first became aware of SD's death after he read an article in the *Chronicle Journal* that stated that a body had been recovered in the McIntyre River and the death was considered as *"non-criminal."* Complainant 2 thought to himself, *"Here we go again."* He explained that over the years he had followed other deaths of young people found in the river with quick determinations by police that the deaths were *"non-criminal."* He said this case appeared to be another instance of the same.

Complainant 2 said that the whole thing seemed *"strange"* to him. The paper indicated that the body was found at 9:30 a.m., on October 19, 2015, and at 1:30 p.m., the following day the investigation determined that there was "*no foul play involved."* He found that determination to be impossible to deduce so early in the investigation and thought that the police were *"making assumptions based on nothing."*

Complainant 2 recalled that there had been a lot of gossip within the community about SD's death, but nothing concrete.

Complainant 2 said that the first time he met Complainant 1 was at SD's funeral. Complainant 1 and his family approached the Chief and Council and asked for help to determine how SD died. They told him that they were not getting anywhere with the police. Complainant 1 told him that he had attempted to ask the police questions pertaining to the circumstances of SD's death, but did not get any information. The family showed pictures of SD and some of the bruising that was visible on his body. He said the more he learned, the more upset he became. Complainant 2 said that they wanted to support the family, and their request for assistance in hiring a lawyer was immediately approved.

Complainant 2 said that he never had any contact with TBPS in relation to the death of SD. He received a call from the Mayor of Thunder Bay once the complaint filed with the OIPRD became public. The Mayor asked if he would sit down and have coffee with him. Complainant 2 said that he considered it, but after discussion with his confidants he chose not to meet with the Mayor because he did not want to taint the OIPRD investigation.

Civilian Witness 1

Civilian Witness 1 provided a *recorded interview with the OIPRD on November 9, 2016. The following is a summary of the relevant portions of the interview.*

Civilian Witness 1 is a Primary Care Paramedic with the Superior North Emergency Medical Services. On October 19, 2015, he was dispatched to Carrick Street and Waterford Street in a response to a body in the river. When he arrived on the scene, police and the civilian who had called 911 were present. He noted that the area had not been cordoned off with police tape at that point.

Civilian Witness 1 said that the location of the body was pointed out to him. He proceeded down the embankment to the river to assess the individual. He pulled the individual to the riverbank and rolled him face up. He determined that the individual was obviously deceased and that no CPR or resuscitation efforts were warranted.

Civilian Witness 1 said that it was apparent at the time that he pulled the deceased out of the water that he was an Indigenous male. That information was not documented in his notes as he did not feel it was pertinent in relation to his duties. Civilian Witness 1 stated that he did not observe any obvious signs of trauma to the body, but did notice a small amount of blood under the deceased's nose. He could not determine if the blood had come from his nose or a scratch on his face.

Prior to departing the scene, Civilian Witness 1 spoke to the officers and advised that the individual was Code 5, (obviously deceased), and that he would not be transporting the body to the hospital. He did not make note of the names of the officers that he spoke to or the name of the deceased as the individual had not been identified at the scene. He was aware that a Health Card had been recovered at the scene, but he did not believe that it belonged to the deceased.

Civilian Witness 1 was on scene for approximately 15 minutes. By the time he left, several officers had arrived and had begun to cordon off the area.

Civilian Witness 1 said that he did not observe anything unusual about the scene. He said that there was no discussion with the officers about the identity of the deceased or about how the deceased ended up in the river. He indicated that he had attended a previous scene with a deceased person in the water in 2013, which involved a Caucasian female who was found in the harbour at Prince George's Landing. Based on that previous experience and his observations at the scene, he did not observe any difference in treatment by police when attending calls of Indigenous individuals compared to non-Indigenous individuals.

He had no further involvement in the investigation.

Civilian Witness 2

Civilian Witness 2 provided a recorded interview with the OIPRD on December 1, 2016. The following is a summary of the relevant portions of the interview.

On October 19, 2015, Civilian Witness 2, in his capacity as Coroner, attended Carrick Street and Waterford Street, where SD's body was found. When he arrived the police, including detectives, uniformed officers and the Forensic Identification Unit (IDENT), were on the scene. The paramedics had already departed the scene.

He observed the individual face down in the river, in two to three feet of water, approximately 15 feet from shore and fully clothed. Civilian Witness 2 noted that the reeds along the river did not look disturbed. He said that there was one area that had a small path that looked as though it had been pushed down, but it was his understanding that someone had walked there shortly before the police arrived.

Civilian Witness 2 said that police advised him that they had searched the riverbank and personal identification was found. They advised that the identification did not belong to the deceased as they believed he was someone well known to them.

Civilian Witness 2 indicated that police took pictures of the riverbank and the surrounding area prior to retrieving the individual from the river. He was assisted by one of the officers who stepped into the river and slowly retrieved the body and brought him to shore.

Civilian Witness 2 checked the individual's pockets and examined his body. He looked for obvious signs of trauma, such as stab wounds, gunshot wounds and possible bone fractures. Following his cursory examination, he discussed with officers what possibly happened to the individual. There were no conclusions drawn at that point.

Civilian Witness 2 stated that they had previous drownings in that area as it was a popular drinking location. He said the people who drowned were mostly alcoholics and were found to have very high levels of alcohol in their blood. He was advised by the police that the deceased was possibly Stacy DeBungee who was known to be a *"heavy drinker."*

Civilian Witness 2 said that the police were going to try to find out what happened to SD and determine whether he had been involved in an altercation or if he had just fallen into the river. The police talked about having to interview people to find out what might have happened. Because of the fact that another individual's identification was found in the area, police assumed that individual had been there at some point and he was a person they wanted to interview to see if he could shed some light on what may have occurred.

Civilian Witness 2 did not recall whether the information that a witness had seen an altercation involving a group of males the previous evening in the location where SD was found was available to him at the time. He said that unless there were large abrasions, large bruising or fractures to the body, it would be very difficult to determine if he had been involved in an altercation.

According to Civilian Witness 2, they had not ruled out foul play, suicide, homicide or accidental drowning. However, the assumption, based on a balance of probabilities, was that SD's death was an accidental drowning.

Civilian Witness 2 spoke with the officers about when the autopsy would be conducted. He believed that he placed an identification band around the body and instructed the officers to ensure the body was secured before being transported to the hospital for the autopsy. He said his duty was to ensure the body was handled correctly as there was always the potential of foul play. He went on to say that absent the account of an eyewitness, it would be difficult to determine what occurred from an autopsy, and he would depend on the police to conduct the investigation.

Civilian Witness 2 indicated that part of his duty, was also to ensure that the pathologist knew the circumstances of the death and to obtain information from the pathologist, including a toxicology report, after the autopsy was completed. He indicated that toxicology reports took, on average, six weeks before they were received. He said that police were responsible for attending the autopsy, taking photographs and recording anything notable.

Civilian Witness 2 was not sure what the police were thinking when they characterized the death as *"non-criminal"* prior to the autopsy being performed. He said that would not have been wise without the benefit of the autopsy results. He thought that they might have made the assumption based on probabilities, and the fact that they did not observe anything at the scene that pointed to an obvious cause of death other than drowning.

Although he did not have the expertise to conclude what the police should have done, he believed that they should have waited for the autopsy results before concluding that SD's death was an accident. He assumed that if the police obtained information that indicated otherwise, they would have pursued an investigation.

Civilian Witness 2 said that he spoke with Complainant 1 and provided him with information about the autopsy. He recalled that Complainant 1 was very angry and had many questions about SD's belongings. He also wanted to know whether SD looked as though he had been assaulted. Civilian Witness 2 advised Complainant 1 to defer his questions to the police and only discussed information from the autopsy with him.

Civilian Witness 2 believed that he told Complainant 1 that SD's death appeared to be an accidental drowning and that he had high levels of alcohol in his system. He could not recall if he knew that information from the toxicology report or from the autopsy. He further advised Complainant 1 that the police were still investigating because they still had to determine why he drowned.

Civilian Witness 2 recalled asking officers on a few occasions whether they found out anything further in the case and he was told no. He could not recall if police informed him that they had interviewed any potential witnesses. He said there may well have been other details determined, but nothing changed what they thought about the death being accidental. It was rare for him to communicate with the detective unless there was something specific they wanted to inquire about. He said that it was also rare for detectives or IDENT officers to attend the autopsy unless there was suspicion surrounding the circumstances of death.

Civilian Witness 2 did not believe that the police were not doing their job or working as hard as they could because the deceased was an Indigenous person. He thought the fact that both the detectives and IDENT officers were at the scene investigating was different from usual as they only attended a scene if there was some suspicion. He stated, *"I hardly ever see the detectives unless there's something that they're really wondering about. So they were obviously there for a while and coming here and making sure they had as much as evidence as they could pull from there."*

Civilian Witness 2 believed the police knew SD, liked him and felt bad that he was deceased. He said that was something that he did not often hear in those circumstances.

Civilian Witness 3

Civilian Witness 3 provided a recorded interview with the OIPRD on February 9, 2017. The following is a summary of the relevant portions of the interview.

Civilian Witness 3 joined TBPS as a Media Relations and Crime Stopper Coordinator in 2003. He became an Executive Officer in 2004. At the time of the incident, he was a senior officer responsible for media relations, as well as internal auditing, IT and Freedom of Information (FOI). He is a civilian member of TBPS and his current position is as the Director of Communication and Technology.

On October 19, 2015, Civilian Witness 3 attended the scene of a sudden death at Carrick Street and Waterford Street. He was not sure what time he arrived, but believed it was about mid-morning.

Civilian Witness 3 said normally the police constable that reported to him would attend the scene; however, she was not on duty that day and he attended in her absence. He thought there was a strong possibility that the media would attend the scene because the death had occurred in a public location.

Once he arrived on scene he sought out [redacted], as he was the detective in charge of the investigation. He inquired with [redacted] about what they were dealing with. [redacted]told him that a body had been discovered in the river and had been moved to the shore. He was told that there was no evidence, at that time, to indicate that it was a homicide and needed more time to determine what happened.

Civilian Witness 3 did not see the body, but observed a number of officers, including IDENT on scene. He told [redacted] they would have to decide what to put out to the media as the media was already present. [redacted] told him that they would discuss the content of what should be released later that morning. Civilian Witness 3 returned to the police station shortly after that.

Civilian Witness 3 said that his role in media relations was to be a consultant to the detectives and provide any logistical work that they required. Any content that went out was only what was approved through the chain of command.

In the first media release, issued on October 19, 2015, at approximately 12:45 p.m., the TBPS wanted to give the public a sense of security. Civilian Witness 3 said that the first question he would ask the investigator was whether public safety was an issue. This was especially so in this instance since the body was discovered near a pathway in a public area. [redacted] advised him that there was no public safety issue.

Civilian Witness 3 said that the release was constructed along the timeline of when the 911 call regarding the discovery of a body was received and the initial investigation that did not indicate a suspicious death. The release indicated that an autopsy would be conducted to determine the exact cause of death. At that point, the deceased had not been positively identified.

Civilian Witness 3 said that he constructed the media release and emailed it to [redacted]. He also copied [redacted] and [redacted] on the email. [redacted] responded that it *"looked good"* and based on that response, Civilian Witness 3 had the authority to release the information. He indicated that he would not release any information unless the content had been approved.

Civilian Witness 3 said that was the usual procedure to approve a media release. He further advised that within TBPS, some detectives who were the lead investigators, as well as Watch Commanders had the authority to issue a media release.

Civilian Witness 3 said that he was comfortable and confident about releasing the information as he knew from past experience that [redacted] and the Criminal Investigation Branch (CIB) had a good handle on where the investigation was going.

The second media release, issued approximately 25 hours after the discovery of the body was not associated with an email chain for approval. Civilian Witness 3 believed that the communication would have been verbal, which was not uncommon. He indicated that he would have spoken to [redacted], [redacted] or [redacted]. Civilian Witness 3 reiterated that he would not have released any information without their approval.

Civilian Witness 3 said that the language used in the second press release was fairly common. The TBPS had struggled in the past with the language that it used with the public to explain ongoing investigations. Had he been asked by a reporter if the investigation was closed, he would have stated, *"It was a continuing investigation and, at this point, there's nothing to indicate it's going to be a criminal matter."*

Civilian Witness 3 was not sure what level of confidence [redacted] had regarding the death being *"non-criminal."* He believed that it may have been a matter of *"probability"* and based on everything that was in front of them, it did not appear to be criminal. He went on to say that in his experience CIB would not completely rule out other possibilities and would not be afraid to go back and look at something that steered the investigation in another direction.

Civilian Witness 3 thought that it was a valid concern expressed by Indigenous people that SD's death was considered *"non-criminal"* before an autopsy had been conducted. He believed that determination could result in the perception that the matter had already been decided. He was confident that the wording *"non-criminal,"* as contained in the second media release, would not be released in the future prior to an autopsy being conducted. He advised that the service was more careful and sensitive to the language and timing of their media releases.

Civilian Witness 3 believed that TBPS learned valuable lessons and have evolved in how it investigated sudden deaths and the release of information to the public. He understood the concerns from Indigenous people and was cognizant that the onus was on the TBPS to foster relationships with the entire Thunder Bay community.

Civilian Witness 4 and 5

Civilian Witness 4 and 5 provided a recorded interview to the OIPRD on November 11, 2016. The following is a summary of the relevant portions of the interview.

Civilian Witness 4 was the common-law spouse of SD and Civilian Witness 5 is her daughter. OIPRD investigators attended Civilian Witness 4's home and spoke to her about SD and her interaction with the TBPS. Civilian Witness 5 assisted her mother in understanding some of the questions posed to her by investigators.

Civilian Witness 5 said that she and Civilian Witness 4 were told by her nephew, AA, that a person was found in the McIntyre River. Civilian Witness 4 was immediately concerned because SD had not returned home after leaving their home at approximately 4:30 p.m., the previous day.

Civilian Witness 4 said that on October 18, 2015, SD received a call from someone who asked him to transfer money into his bank account. She could not recall who the person was. She said that SD agreed to receive the money. He left their home and stated that he would be back in about 20 minutes.

Civilian Witness 5 described SD as a very kind person who loved her mother. She stated, *"He was a very respectful man who took care of my mother and he cared about us too. He helped us so much whatever the situation was. You know, he's a very happy guy. He loved helping people that's why he did that for people like transfers and stuff. He would even feed people and he would even take what he had on and give it to the person if they needed it, that's the kind of man he was."* She said that SD was enrolled in school studying math and English.

Civilian Witness 4 said that AA helped her contact the police to see if the body found in the river was SD. She said that he had been known to drink in the area on occasion.

According to Civilian Witness 4, she only spoke to police on one occasion. She said that they attended her home to inform her that they had identified a deceased male who was found in the river as SD. They did not provide her with any information about SD's death.

Civilian Witness 4 said that she could not recall if the police told her that they were investigating what may have happened to SD. Nor could she recall who else was at the house at the time the police were there. However, Civilian Witness 5 advised that some of the people who were with SD the evening before his body was discovered were at the house when police were there.

Since the initial contact, the police did not communicate with Civilian Witness 4 until a year later when [redacted] attended her residence to update her on the on-going investigation into SD's death.

Civilian Witness 5 said that both she and Civilian Witness 4 needed to know what happened to SD in order to get closure or, at the very least, answers. She stated, *"I been watching my mom go through this and I knew soon, at least somebody should come and tell us what's going on because you know, why was he falling in a river like that? Why did those people leave him there just like that? Like, you know, obviously something happened and the way I feel for myself you know there's something there."*

Civilian Witness 5 said that she did not believe that the police did anything much for Civilian Witness 4. She expected the police to keep them informed, but there was no communication for nearly one year. She said that they wanted to be kept abreast of the investigation and wondered why the police never contacted them.

Civilian Witness 6

Civilian Witness 6 provided a recorded interview with the OIPRD on November 11, 2016. The following is a summary of the relevant portions of the interviews.

Civilian Witness 6 is SD's cousin. Their mothers were sisters and they grew up together. As teenagers, they hung out together until SD moved to Toronto, then to British Columbia before moving back to Thunder Bay. She said that as time went on and their *"life patterns changed,"* they were not as close as they once had been. The last time she saw SD was sometime in August, 2015.

Civilian Witness 6 said that on October 19, 2015, at approximately 11 a.m., she received a phone call from her daughter who advised her that SD had passed away. Her daughter informed her that a cousin learned through Facebook that they found SD's body in the McIntyre River. She was told that the police released the information to the media and it had been posted on Facebook. Civilian Witness 6's first concern was that no immediate family members were contacted by police and advised that SD had passed away before the information appeared in the media.

Civilian Witness 6 contacted another cousin, who was Complainant 1's girlfriend, and told her that SD had been found in the river. Neither her cousin, nor Complainant 1, was aware of what happened to SD.

Civilian Witness 6 said that several of her relatives gathered at her house later that day. She said that no one knew who SD's common-law spouse was, but later learned that she had identified SD's body by a photograph.

On October 21, 2015, Civilian Witness 6 attended TBPS with Complainant 1 and their aunt. She said that they met with approximately four to five detectives. She asked the detectives how the information about SD was released before any of the family members were notified. They advised that they had notified his common-law spouse and she positively identified him and that was why they released his name. She said that police would not even tell them the common-law spouse's name even though they had notified and acknowledged her as being SD's next of kin.

Civilian Witness 6 said that she did not ask the detectives too many questions. Complainant 1 asked most of the questions, but the police would not divulge much information. Throughout their meeting she said that Complainant 1 remained calm despite the fact that they were all in a state of *"shock"* as the death of SD was something they never expected. Civilian Witness 6 said at no time during their conversation did the police offer or suggest support services for them or their family.

According to Civilian Witness 6, the police made no reference to the fact that SD may have been in the company of other people prior to his death. The police told them that SD was drinking by the river and had passed out on the riverbank with another person. That person had left by the time the police arrived in the morning. The police would not provide them with the name of that person.

The police theory was that SD passed out on the riverbank, rolled into the river and drowned. They gave no indication that they believed his death may have been suspicious. She said that Complainant 1 was dissatisfied with what they had been told by police.

Civilian Witness 6 said that after they left the police station, they decided to go to the location where SD's body was found. They drove directly from the police station to the riverbank. After they were on scene for a few minutes, [redacted] arrived. She found it *"funny, almost as though they were being followed."*

After attending the scene, Civilian Witness 6 felt that the explanation the police gave them did not seem plausible. She said that there were trees and debris around the area where they indicated SD had rolled into the river. She thought that if he had rolled down the embankment, he would probably have hit a tree. She also noted that the grass in that area was not flattened down or trampled in any way.

Civilian Witness 7

Civilian Witness 7 provided a recorded interview with the OIPRD on May 29, 2017. The following is a summary of the relevant portions of the interview.

Civilian Witness 7 is a retired member of the Toronto Police Service (TPS). In his 28 year career he worked in several capacities, spending the majority of his time in the investigative field. He was experienced in human trafficking, child prostitution and undercover drugs investigations. He also worked in the homicide unit for three years before being promoted to rank of Detective Sergeant.

As Detective Sergeant he ran the detective office at 42 Division for several years. At the time of his retirement, Civilian Witness 7 was the Officer in Charge of the Sexual Assault Squad in the Sex Crimes Unit.

Following his retirement in January 2004, he took a teaching position at Durham College as an Adjunct Professor in the School of Justice. Just over 10 years ago, Civilian Witness 7 became the founding partner of Investigative Solutions Network (ISN), which is primarily a private investigation firm. He is currently the CEO of the company as well as a licenced Private Investigator in the Province of Ontario.

Civilian Witness 7 said that he was retained by the law firm representing the Complainants to review TBPS's investigation into SD's death. The Complainants did not believe that a competent investigation had been undertaken.

On November 16, 2016, Civilian Witness 7 met with the lawyer representing the Complainants in Thunder Bay. He had been provided with some relevant materials and briefed on the circumstances of the case. During the briefing, he was introduced to BB who was a community member from the Rainy River First Nation (RRFN). BB assisted him with meeting SD's family and potential witnesses.

Civilian Witness 7 said that one of the first things he did was to meet with Complainant 1. He (Complainant 1) shared with him some photographs he had taken during the funeral service for SD. Complainant 1 believed the photographs showed suspicious bruising on SD that should have been cause for concern.

Civilian Witness 7 noted that the photographs were taken after the autopsy and after the body had been tended to at the funeral home. With only the information provided by Complainant 1, he found it very difficult to make any kind of accurate determination about what may or may not have happened. He conveyed his assessment to Complainant 1.

On November 17, 2016, Civilian Witness 7 interviewed Complainant 1 at length. During the interview, Complainant 1 divulged that he was very suspicious of the family of SD's common-law spouse. Complainant 1 felt that perhaps there were some issues around control and substance abuse. He informed him that SD was on the Ontario Disabilities Support Program and received payment each month that paid for his apartment. SD also received an additional $30 or $50 on Tuesdays and Thursdays and had a debit card used to access his accounts.

Complainant 1 described SD as a *"kind of a happy-go-lucky guy who was always smiling."* He told him that SD never hung around the river and was *"surprised"* when he was told that SD's body was found there.

Complainant 1 told him that the last time he saw SD was about two weeks prior to his death and all seemed normal. Complainant 1 stated, "*He seemed happy – his usual story-telling and, laughter."* Complainant 1 noted a bruise over SD's left eye. SD told him it was from Civilian Witness 4's son, who beat both of them because he wanted their bed. They eventually had to call police to have her son removed from the apartment.

Civilian Witness 7 said that Complainant 1 told him that he, Civilian Witness 6 and their aunt attended TBPS on October 21, 2015, to meet with [redacted] the officer in charge of the investigation. When they arrived, they were told that [redacted] was unavailable until later that afternoon. At approximately 1 p.m., [redacted] and [redacted] and [redacted] met with them.

Complainant 1 told him that the investigators found another person's identification scattered in the area where SD was found and apparently that person had arrest warrants and did not want to be found by police. Complainant 1 was given no indication from police whether the person had ever been located. Complainant 1 also told him that the police said they had deduced that SD had fallen asleep and rolled into the river and they did not suspect any foul play. He was told that the Coroner would be performing an autopsy on October 23, 2015, and that they would have to wait in order to view the body.

At the meeting, Complainant 1 told detectives that he heard that there were some young Native guys who were found in the water and that *"things were being thrown under the carpet."* Civilian Witness 7 was told by Complainant 1 that [redacted] raised his voice and replied, *"No, not here. We're doing everything to investigate this properly."*

Civilian Witness 7 was advised by Complainant 1 that he spoke to the Coroner who confirmed that SD had been found face down in the river. The Coroner further confirmed that death was caused by drowning. The timeline given by the Coroner was between 7:30 p.m., on October 18 to 9:30 a.m., on October 19, 2015, when the body was discovered.

According to Civilian Witness 7, the hardest thing to do in a death investigation was to narrow down the time of death as there were a lot of variables that could impact on the state of the body.

Complainant 1 told him that he asked the Coroner for a second opinion and he was told that he was the only Coroner in the area. Civilian Witness 7 said that in his experience a family could request a second autopsy. He said there would usually be a discussion with the Coroner's Office and the family about whether a second autopsy was feasible. He said it was not common, but in some instances could happen.

Civilian Witness 7 said that after hearing what Complainant 1 reported, it was his impression that there may have been a little bit of conflict between Complainant 1 and [redacted]. He observed that because SD's death occurred almost in the middle of a significant inquest into deaths of Native youths in the river over the past decade, there was a lot of mistrust between the community and the police.

> *"I think there was some friction, but I was encouraged that the detectives at least took the time to go down to the area. And I'm assuming they went down to the area because [Complainant 1] had said he was going to go down to the area and they assisted him and helped him to actually find the exact location where his body had been recovered."*

Civilian Witness 7 said that he was familiar with the relationship between TBPS and the First Nations community. He met with Complainant 2 and others who informed him about the tensions and their mistrust of the service.

Civilian Witness 7 described the relationship between the Indigenous population and the police as *"a community's crisis of confidence."* He said that when he met with Complainant 2 he felt that his community had no trust in the police. In turn, there was no trust from the police leadership. There seemed to be a real breakdown between the police and the First Nations community.

He said he had been provided with copies of the early news releases reporting the recovery of a body in the McIntyre River. He noted, with interest, that there was at least an article or two that made reference to *"no criminality or no foul-play was suspected."* In his view, that was really early in the investigation to actually make that determination. Civilian Witness 7 said that was *"one of the first flags that was raised"* for him.

> *"That they were so quick to go to the media and say that no foul play was suspected and that there was no criminality. As an investigator, and especially somebody that's experienced in death investigations, that just seemed like that was happening long before, you know, the police had time to interview people, speak to the family, speak to any potential witnesses, the last people who saw him and so on. And certainly to see what the Coroner had to say."*

Civilian Witness 7 said that the presumption that there was no foul play was made even before they had positively identified SD or before an autopsy had been performed. He said that the circumstances or the cause of death should be addressed by the Coroner post-autopsy. However, in fairness to police, sometimes they would make an announcement for public safety and to ease the community's fears.

Civilian Witness 7 said that it was his opinion, in light of all the circumstances surrounding the case, including the ongoing Coroner's inquest that it was premature to announce that there was no criminality on the same day the body was recovered. That could not actually be stated as fact. He thought that the way things were done were not in sequence and perhaps a little insensitive to the community. He said it certainly was not in keeping with the standard protocols of death investigations.

Civilian Witness 7 said that he started his investigation by speaking to family members. He then spoke to the people who were at the river drinking with SD the night before he was found in the river.

Through his investigation, Civilian Witness 7 was able to put together what SD did on the day prior to his death. He learned that SD had left his home that day to meet with his common-law wife's niece and her boyfriend to accept a money transfer. They usually gave SD cigarettes, a bottle of wine or $10 for using his account.

Civilian Witness 7 found out that there were approximately five individuals with SD prior to his death who had never been interviewed by the police. It was his understanding that the family had not yet been interviewed or spoken to by the police either.

Civilian Witness 7 said that he attempted to find three of the people who were last seen with SD as he learned that two had moved away shortly after his death. He was unable to find them after checking several locations where they were commonly known to be. He said that he wanted to see if they had any information about the last time they saw SD.

Civilian Witness 7 said that anytime he conducted an investigation and could assist police or provide them with any information he would do so. He attended the TBPS with Complainant 1 and asked to speak to [redacted]. He was told that he was not on duty at that time. Instead, they met with another officer who spoke to them for a few moments. Civilian Witness 7 identified himself and provided his business card. He found the officer's demeanour *"closed"* and almost *"resentful"* that Complainant 1 was there. He stated, *"I didn't find that he was treated with any respect whatsoever and I felt like we were just brushed off and shovelled back out the door and he had no interest in [Complainant 1] or me or any information that I might have whatsoever."*

Civilian Witness 7 requested that [redacted] call him back so he could share that information. He said that he had never been contacted by [redacted] or anyone from TBPS. He said that he was not surprised that he did not get a call back based on the reception he received.

Civilian Witness 7 said that the majority of times, he would be greeted with an open door policy in police services across North America. As soon as he told the police who he was, he would enjoy the usual brotherhood/sisterhood that existed worldwide among officers. He said they wanted to hear what he had to say because it just might be relevant.

Civilian Witness 7 said that based on his experience, he was able to develop a lot of unanswered questions. He stated that an investigation should not be stopped until the answers to all the questions were sought and subsequently found. He noted that there were rumours that there was a fight at the river that night and SD might have been assaulted; if he was assaulted, why? And, did that assault lead him to fall into the river? The TBPS investigation did not look into any of that.

Civilian Witness 7 stated that even if it was believed that SD was intoxicated and somehow rolled into the river after falling asleep and drowned, it was still a death investigation that should have been investigated to the highest standards. He said that had he investigated the incident, he would not have written it off as simply being a drowning because there were too many unanswered questions. There were several people who needed to be interviewed and possibly polygraphed. He said that the person whose identification was found near SD needed to be interviewed and polygraphed.

Civilian Witness 7 indicated that there was a lot of work that needed to be done and believed that the police needed to fill in all of the blanks to get a clearer picture of what may have happened to SD.

Civilian Witness 7 believed this case should have been classified as a *suspicious death*. He believed it would have been better to approach the investigation from that perspective and not make assumptions.

Civilian Witness 7 said that when he left Thunder Bay, there were so many unanswered questions that SD's family and the community would never have felt confident in TBPS. What really needed to be done was *"a full and frank investigation, full transparency and reporting back to the family."*

Civilian Witness 7 referred to the policies and procedures, guidelines and protocols for doing death investigations. He described the relationship between the Coroner's office and the police. He stated that part of the responsibility of the Coroner's office was the autopsy. The police should be present during an autopsy in order to listen, make notations and gather information and evidence. He said by saying it was a *"Coroner's case"* was a way of *"clearing your plate"* and diverting responsibility to somebody else. He reiterated that it was the responsibility of the police to conduct any investigation outside of the autopsy.

Civilian Witness 7 said that timelines for obtaining evidence were always paramount and went to the relationship with the family and the community. He stated that you only get one chance at building rapport and trust with the family and that was why police should always contact the family first and not let them find out about the death of a loved one through the media. If a family believed that something untoward happened to their loved one, it was up to the police to take that seriously and investigate the matter. Unfortunately, that did not happen in this case.

Civilian Witness 7 said the police had "*tunnel vision"* in relation to the investigation. The police acted as though they had another intoxicated Indigenous person who fell asleep at the river and the only probability was that he rolled into the river and drowned. He pointed out that the TBPS was in the middle of a Coroner's Inquest, exploring the alleged lack of investigative steps by the police in the past and the lack of trust in the police by the community. He personally believed that the Chief of Police or any senior manager should have paid stricter attention to SD's death. They should have ensured that all the right people were involved in the investigation and that all the right steps were being taken.

Civilian Witness 7 thought that one of the biggest steps that were missed was the lack of a family liaison person to communicate with and provide information to, and more importantly, ask for information from the family. He found it extraordinary that no one from TBPS spoke to SD's common-law spouse, the fact that an announcement was made so early in the media that there was *"no criminality"* and the fact that the family was finding out about SD's death through social media.

Civilian Witness 7 advised that he previously taught Major Case Management before he retired from policing and as a fairly regular part of his role, he would review police investigations. He found that 99 per cent of the time, police have done an adequate job and in some instances have even gone above and beyond on a death investigation. He said that this investigation was one of the rare cases where he had the opposite experience. He naively expected that the police had, in fact, done a really good job, but they had not. He was left with the impression that they had not done a good job because the death was swept away as just another drowning of an intoxicated, Indigenous person. He said he found that to be wrong.

Witness Officer 1 – [redacted]

[redacted] *provided a recorded interview with the OIPRD on November 11, 2016. The following is a summary of the relevant portions of the interview.*

On October 18, 2015, [redacted] was a member of the Uniform Patrol Unit. He had no direct involvement in the SD investigation. However, on that date he had an encounter with CC, one of the individuals believed to be with SD the night prior to his death, at the SilverCity movie theatre.

[redacted] and his partner [redacted] were dispatched to attend to an intoxicated male sitting inside the movie theatre in a wheelchair. At 9:30 p.m., they arrived at the movie theatre and found CC on the front steps.

[redacted] informed CC that he was not allowed to idle on the front steps and that he was bothering some of the theatre staff. [redacted] noted that CC had been drinking, but not to the extent of being intoxicated.

[redacted] was uncertain whether CC had been at the theatre alone, or whether there were other people with him prior to his arrival. He asked CC whether he was at the theatre alone, and CC responded yes. When asked how he arrived at the theatre, CC advised that he had someone push him there. CC stopped mid-sentence when he realized that he had been caught in a lie. [redacted] noted that he was familiar with CC's name from a previous encounter and that lead him to question how he arrived at the theatre.

CC then asked [redacted] for a ride, but [redacted] declined. CC then wheeled himself southbound on May Street towards Shelter House.

[redacted] submitted his notes about his interaction with CC via a supplementary report. The supplementary report was requested by [redacted] who was involved in the SD investigation.

[redacted] stated that he was only familiar with SD's name from the radio and had no personal encounters with him prior to his death.

Witness Officer 2 – [redacted]

[redacted] *provided a recorded interview with the OIPRD on November 11, 2016. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS for over four and a half years. He is currently assigned to the Uniform Patrol Unit.

[redacted] had no direct involvement in the SD investigation. On October 18, 2015, he had an encounter with CC at the SilverCity movie theatre. [redacted] received a call that there was a male at the SilverCity movie theatre who appeared to be intoxicated and was unwanted on the property. [redacted] arrived at the theatre, with his partner [redacted] around 9:30 p.m., and found CC sitting alone in a wheelchair.

CC told [redacted] that he had arrived at the theatre under his own power. [redacted] recollection of how CC said that he arrived at the theatre differs from that of [redacted], who was told by CC that someone helped push him to the theatre. There was a brief discussion as to where CC was heading and then he left the movie theatre. [redacted] found that CC was not intoxicated enough to pose a threat to himself or the public.

CC asked for a ride from [redacted] and [redacted] but they refused and explained that the police cruisers were not equipped to transport wheelchairs.

Witness Officer 3 – [redacted]

[redacted]i provided a recorded interview with the OIPRD on November 10, 2016. The following is a summary of the relevant portions of the interview.

[redacted] has been a member of TBPS since August, 2006. He is currently assigned to the CIB.

In August 2016, [redacted] and [redacted] requested that [redacted], along with [redacted], follow up with three people who were believed to be in the company of SD the evening prior to his death. The three witnesses were CC, DD and EE. Although it was not explicitly stated that the investigation was of high priority, it was noted that the follow up should be done in a timely manner.

At the time, [redacted] understood that the investigation was still ongoing and that it was characterized as a *"sudden death"* investigation. Prior to his involvement, [redacted] had no knowledge of the investigation and only reviewed the file upon being assigned to the investigation in August, 2016. [redacted] recognized SD's name, possibly due to his many encounters with the police; the same was also noted for CC.

[redacted] located CC and EE, but was still trying to locate DD at the time of the OIPRD interview. He noted that it had been difficult to locate CC and EE because they lived outside of Thunder Bay, while it was believed that DD resided in the city. From his interviews with CC and EE, [redacted] was able to ascertain the names of other people who might have more information regarding SD's death. Some of those people had already been located, while others were still being looked for. There was also information obtained through a missing person report statement that required follow up. At that point in time, there was no *"person of interest."*

Witness Officer 4 – [redacted] *provided a recorded interview with the OIPRD on November 10, 2016. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS since December 5, 1988. She is currently assigned as a Resource Officer. In her capacity as Resource Officer, [redacted] was responsible for all incoming complaints/inquiries that came through TBPS.

On October 19, 2015, at 2:14 p.m., [redacted] received a phone call from AA who wanted to file a missing person report for SD on behalf of Civilian Witness 4. The conversation was interrupted by EE who informed [redacted] that she and some friends had been drinking with SD on October 18, 2015, around 5 p.m., in front of the Shoppers Drug Mart near the SilverCity movie theatre.

EE said that she was in the company of FF, DD and her boyfriend, CC. EE further informed [redacted] that she, CC and DD had left early, leaving FF and SD passed out by the riverbank. EE said she had no further information on the matter.

After the phone call, [redacted] submitted the missing person report to CIB for investigation. She advised that she was aware that a body had been recovered in the McIntyre River earlier that day and there were suspicions that it was SD. However, the identity of the body had not been confirmed at the time of AA's phone call.

[redacted] had no further involvement with the investigation.

Witness Officer 5 – [redacted] *provided a recorded interview with the OIPRD on November 10, 2016. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS since 2007. He is currently assigned to the Forensic Identification Unit (IDENT). His duties included examining and documenting scenes and collecting evidence.

On October 21, 2015, [redacted] asked [redacted] to attend the autopsy examination of SD. [redacted] had not attended the scene where SD's body was found and had no involvement in the investigation to date. Nonetheless, he agreed to attend the autopsy and was responsible for taking photographs of the deceased's face, body and limbs, and any additional photographs at the direction of the pathologist.

[redacted] stated that he also took pictures of some minor scratches and cuts on the deceased, but did not notice any unusual markings that raised suspicion. He stated that in many cases where bodies are found in the water the autopsy revealed very few injuries.

[redacted] said that he took approximately 30 to 50 photographs during the autopsy. The photos were uploaded to the police database and the samples collected were sent to the Centre for Forensic Sciences.

He had no further involvement in the investigation.

Witness Officer 6 – [redacted]

[redacted] *provided a recorded interview with the OIPRD on December 2, 2016. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS since December 2005 and a police officer since April 2006. He had been assigned to IDENT since December 2012. [redacted] did not attend the scene where SD was located.

On October 21, 2015, he attended the autopsy, along with [redacted], who he was training at the time. Their role was to take photographs of the body at the direction of the pathologist and to obtain biological samples that they would submit for toxicology testing. [redacted] said that he and [redacted] attended the autopsy because the officers who had attended the original scene were off-duty.

He stated that the role of the IDENT was to photograph the scene and collect evidence. The officers would bag the body and the hands of the deceased and tape around the hands to secure possible DNA evidence from the fingernails. He did not recall whether SD's hands were bagged. He believed that the photographs from the autopsy could help determine that.

[redacted] indicated that he did not have an independent recollection of the autopsy. It was only after he reviewed his notes that he realized he was present. His notes reflected that they observed some minor injuries that were photographed. The pathologist indicated that the anatomical cause of death was likely drowning, pending the toxicology results.

[redacted] stated that the biological samples were submitted by [redacted] and the results were sent directly to the pathologist.

[redacted] did not recall any conversations within the service about what might have happened to SD. He stated that he had attended other drowning cases in the city and it was his experience that IDENT worked in conjunction with the Coroner because it was a Coroner's investigation.

Witness Officer 7 – [redacted] *provided a recorded interview with the OIPRD on November 10, 2016. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS for 25 and half years. She is currently assigned to CIB.

On October 19, 2015, [redacted] requested that [redacted] obtain a photograph of FF, a man suspected to be a possible match for a body found in the river. By the time [redacted] arrived at the scene with the photograph of FF, other officers had located identification which identified the deceased as SD.

[redacted] stated that it did not appear that SD's death was of a suspicious nature.

In May 2016, [redacted] had additional involvement in the investigation. She received a phone call on her day off from [redacted] who advised her that [redacted] had obtained information from GG about a woman named HH who claimed to have pushed SD into the river following an altercation. The request seemed urgent.

[redacted] was unsuccessful when she attempted to contact GG at the phone number provided. She was eventually informed by GG's relative that she had left town for a couple weeks. [redacted] intended to follow up with GG upon her return, but the task was re-assigned to [redacted]

[redacted] also attempted to reach HH. Through her efforts she learned that HH had passed away the week prior to GG's call to [redacted] subsequently became involved in the death investigation of HH. She had no further involvement in the SD investigation.

Witness Officer 8 – [redacted] *provided a recorded interview with the OIPRD on November 10, 2016.* The following is a summary of the relevant portions of the interview.

[redacted] has been involved in policing for over 21 years, serving as a member of the Ontario Provincial Police (OPP), TBPS, and as a training officer for the Afghan National Police in anti-corruption activities. He is currently assigned to the Uniform Patrol Branch.

On March 28, 2016, [redacted] was requested to assist [redacted] in locating a witness named JJ and to be present during the interview. They attended JJ's known address, but were unable to locate him.

[redacted] said that he did not know the reason why [redacted] wanted to locate JJ, nor did he follow with him whether JJ was ever located.

[redacted] had no further involvement in the investigation.

Witness Officer 9 – [redacted] *provided a recorded interview with the OIPRD on November 10, 2016. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS since December 2007. He is currently assigned to the CIB.

On June 30, 2016, [redacted] asked [redacted] to follow up with a woman named GG. [redacted] described the background for the request in similar terms as provided by [redacted]

[redacted] attended the hospital and located GG, who had been the victim of a domestic related incident. When [redacted] arrived at the hospital GG refused to speak to him. [redacted] colleague, from the domestic violence unit, who had arrived prior to him, proceeded to interview GG regarding her involvement in the domestic related incident.

[redacted] asked GG a second time whether she felt comfortable speaking to him. At that time GG agreed to be interviewed. The interview took place at the TBPS.

During the interview, GG informed [redacted] that she had encountered a woman by the name of HH. She recognized HH from her home reserve. GG stated that HH was intoxicated and in need of assistance. She contacted 911 and remained at the scene until the police and ambulance arrived and transported HH to the hospital.

Later that same evening, GG went to the hospital with her sister for an appointment and noticed HH on a stretcher still intoxicated because she had a hidden bottle of Listerine in her pocket. GG approached HH and asked her why she continued to drink. HH replied that she was having nightmares and visions about pushing SD in the river. HH continued and said that she was not strong enough to pull his body from the river, and instead watched his body float away.

GG informed [redacted] that she had seen HH's name in the obituaries and that triggered her memory of her encounter with HH at the hospital.

[redacted] found GG to be a credible witness and stated that her account mirrored what she told [redacted] had not reviewed the investigative file on SD prior to his interview with GG.

[redacted] had further involvement with the SD investigation in August, 2016, when he and his partner, [redacted] were requested to follow-up on a few addresses. One of the addresses was for DD, the only name that [redacted] could remember at the time of his OIPRD interview.

[redacted] stated that DD was not located at the given address, but another man who answered the door provided him and [redacted] with information as to DD's current location. However, DD was not part of [redacted] current caseload, so he did not follow up with locating him at the address they obtained.

[redacted] informed the OIPRD that he was not familiar with, nor did he recall any discussions regarding the SD investigation. He said, since that investigation was not part of his caseload he had no reason to inquire about it and only focused on his own caseload.

Witness Officer 10 – [redacted] *provided a recorded interview with the OIPRD on December 2, 2016. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS since June 1995. When he was interviewed by the OIPRD, he was assigned to the CIB.

On October 19, 2015, at 9:36 a.m., [redacted] was assigned by [redacted] to set up crime scene tape along the perimeter of the scene where SD's body was located. He did not observe, nor overhear, any conversations regarding the investigation while he was at the scene.

[redacted] had no further involvement with the investigation.

Witness Officer 11 – [redacted] *provided a recorded interview with the OIPRD on January 13, 2017. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS since June 1987. At the time of the incident he was assigned to the CIB.

On October 19, 2015, [redacted] was informed by TBPS communications that a body had been recovered in the river. He was told that identification had been found on the riverbank with the name FF on it. [redacted] had a conversation with [redacted] regarding the identification as there was some concern about the identity of the deceased. [redacted] did not attend the scene.

[redacted] was notified about the press release concerning the investigation, but he was not consulted about the information contained in the release. He said that any information that was included in the media release was provided by [redacted].

On May 12, 2016, [redacted] was contacted by GG, who informed him about an encounter she had with a woman by the name of HH. GG advised him HH was intoxicated and appeared to be in need of assistance. She called an ambulance and HH was transported to the hospital.

Later that evening, GG attended the hospital and encountered HH again. GG asked HH why she was a heavy substance user. HH confessed to her that she was having nightmares about a night when she was by the river, intoxicated, and was involved in a *"shoving match"* with SD. HH stated that SD ended up in the river and she was not strong enough to pull him out of the water and his body floated away.

At the time GG came forward with that information, [redacted] was aware that HH had already passed away based on an investigation into her death. He provided a copy of his report from the HH investigation to [redacted] with the knowledge that it could be helpful in the SD investigation. He also verbally shared the information he learned from GG with [redacted] However, when [redacted] was re-assigned to the SD investigation, he was unaware of GG's statement because it had been included in the HH investigative file.

[redacted] stated that he had no further involvement in the SD investigation.

Witness Officer 12 – [redacted] *provided a recorded interview with the OIPRD on January 13, 2017. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS for 28 years. At the time of his interview, he was assigned as the Supervisor of the Drug Unit and had previously been in the CIB for 11 years.

[redacted] was not involved in the original investigation into the death of SD. On October 27, 2016, he was assigned by [redacted] to continue the investigation into SD's death. He was partnered with [redacted]. Although not explicitly stated, [redacted] deemed the investigation to be of an urgent nature.

[redacted] said that he first reviewed the information contained in the file. Included in the file was the OIPRD complaint and the ISN Investigative Report. He stated that he continued to review new occurrence reports as they came to his attention.

Once he reviewed the file, [redacted] followed up with several people who had not been spoken to or interviewed previously. He began by formally interviewing SD's common law partner, Civilian Witness 4.

[redacted] also followed up with a witness noted in [redacted] report. It was not a formal interview and took place over the phone. The witness, KK, reported to him that he had witnessed SD and his friends by the river the evening prior to SD's death. He indicated that he saw two people in an altercation as the rest of the group stood by watching. The following morning, KK passed by the same route and discovered SD's body in the river.

[redacted] also interviewed the people who were present the night before SD's death: The individuals were CC, FF, EE and DD. None of those witnesses had been interviewed prior to [redacted] assignment to the case.

When [redacted] located CC and FF, he asked about the alleged altercation with SD. [redacted] noted that there were conflicting accounts between the two as to what had transpired. One said that he was arguing with his brother while the other stated that there was no argument. [redacted] stated that he had difficulty locating DD. He was aware that he had been in custody on two occasions; however, he was not able to speak to him about the investigation.

[redacted] said that he learned that the reason for the group meeting that night was to execute a financial transaction. He elaborated, *"It was common practice that when people would come in from other northern communities, they knew SD was one of these folks who have a bank account. So if they wanted money, they would have a relative or someone from their First Nation wire the money to SD's account and he would make the withdrawal."*

[redacted] retained the financial records in relation to SD's debit card. He noted, as was previously discovered in the ISN investigation, that SD's card continued to be used after his death. He discovered that Civilian Witness 4 was responsible for the transactions. Civilian Witness 4 informed [redacted] that the pin number for the debit card was *"no big secret."* Civilian Witness 4 stated that she had used the debit card to buy liquor and cigarettes.

Other than those transactions, there were four other minor transactions following SD's death. When [redacted] received the financial statements at the end of November 2016, he noted that there was no further activity on the account.

[redacted] also attempted to locate people who could corroborate GG's account that HH pushed SD into the river. [redacted] indicated that there were some inconsistencies in what GG had reported and noted that she only came forward after HH's death. He contacted a counsellor who GG had apparently confided in about HH's confession. GG said it was that counsellor's encouragement that led her to contact police.

When [redacted] contacted the counsellor, she had no recollection of the conversation with GG. [redacted] also spoke to LL**,** who was listed as HH's next of kin. LL had no recollection of HH confiding in her about an altercation with SD.

At the time of the OIPRD interview, [redacted] was trying to locate another person who was presumed to be a close friend of HH to see if she could corroborate any of the account provided by GG.

[redacted] also tried to locate QQ, who was HH's common law partner prior to her death. QQ was presumed to be residing in Thunder Bay. However, he had several outstanding *"fail to attend"* warrants, and all attempts made to locate him were negative.

[redacted] indicated that the issue of a group pushing Indigenous people into the river had not been raised with him. Although he did not view SD's body, he reviewed the pathology report. The report did not indicate any external injuries to SD. He was informed by Civilian Witness 5 that SD would *"routinely drink and then fall over."* [redacted] attributed the minor injuries on SD's body to those incidents.

[redacted] believed that there were many unanswered questions as to whether SD's death was accidental or criminal. He noted that when he spoke to Civilian Witness 5, she said she *"had a feeling"* that something bad had happened to SD. The same feeling was reiterated by SD's friend, MM, who felt that SD would not have remained at the river *"once the liquor was all gone."*

Witness Officer 13 – [redacted] *provided a recorded interview with the OIPRD on December 20, 2016. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS since October 1, 1984. He was a member of the Uniform Patrol Unit for three and a half years, and subsequently joined the OPP Joint Forces Operation of the Drug Enforcement Branch for five years. He then returned to TBPS in 1992, working in various branches including CIB and Intelligence. In 2011, [redacted] was appointed [redacted] He has since [redacted]

As [redacted] his duties included oversight of all operational branches within the TBPS, as well as the corporate services branch. He also assisted the Chief of Police with any other issues.

[redacted] was first made aware of the SD investigation a couple of days after SD's body was discovered. He said that he did not focus his attention on the investigation until a complaint was filed against the officer involved in the investigation in April 2016. At the time the complaint was received, detectives had determined that there was no evidence of any criminal activity, despite the fact that there were several witnesses who still needed to be interviewed.

[redacted] said that he reviewed the complaint and then met with [redacted] to discuss whether any changes needed to be made in relation to the investigation. [redacted] was concerned that the original detectives, [redacted] and [redacted] had prematurely concluded that SD's death was accidental before they had obtained conclusive autopsy results or completed witness statements. [redacted] also had concerns about the financial transactions involving SD's debit card after his death. He noted that [redacted] and [redacted] were made aware of the transactions on SD's debit card, but failed to act on the information in a timely manner.

After [redacted] meeting with the Chief, the decision was made to ensure that the investigation received immediate attention and to remove the current detectives from the investigation.

[redacted] expressed concern that Civilian Witness 7, the private investigator retained by the Complainants, was able to obtain information from witnesses more efficiently than the police. He attributed their lack of efficiency to the Indigenous witnesses' reluctance to speak to the police. He did not attribute the inefficiency to racial bias on the part of the investigators against Indigenous people.

[redacted] believed that all drowning cases were treated equally and given immediate attention because of the sensitivity of such cases. He said that investigators were aware of the importance of those before the SD investigation. He stated, *"Officers are human. They make mistakes."*

However, he believed that the SD investigation was not conducted as well as it could have been by the original detectives. Based on his dissatisfaction, he requested that [redacted] and [redacted]i take over the investigation.

[redacted]said that he met with [redacted] weekly to discuss the progress of the investigation. Some of the discussions were about the difficulty in locating some of the witnesses, as well as obtaining the financial records related to SD's debit card.

[redacted] was made aware of an individual, KK, who witnessed the presence of a number of Indigenous people in the area where SD was found, two of whom were involved in an altercation. [redacted] had taken KK's statement and filed a supplementary occurrence report pertaining to that statement.

[redacted] said that [redacted] updated him on the progress of the investigation and informed him that he had followed up with the witnesses and the other individuals related to the investigation.

[redacted] said that he did not involve himself further in the investigation.

Summary of Statements – Respondent Officers

Respondent Officer 1 – [redacted] *provided a recorded interview with the OIPRD on December 1, 2016. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS since April 2007. At the time of the interview he was assigned to the Uniform Patrol Division.

On October 19, 2015, [redacted] was partnered with [redacted]. They were dispatched along with [redacted] to respond to a body in the river at Carrick Street and Waterford Street. When [redacted] and [redacted] arrived at the scene, [redacted] was already there with paramedics. The male had been pronounced deceased by the paramedics on scene.

[redacted] felt it was necessary to gather the names, dates of birth and addresses of any potential witnesses and spoke to three people briefly. The three individuals he spoke with were NN, OO and QQ. He indicated that they did not provide any relevant information to pass on to the CIB officers.

[redacted] observed that the body of the deceased was on his stomach face down. The deceased was wearing a tan jacket and blue jeans. There was an Ontario Health Card found on the riverbank in the name of FF. That led him to believe that the deceased was FF.

[redacted] advised that [redacted] attended the scene. He requested that he, along with [redacted] and [redacted], secure the scene. Support services were called in, including CIB, IDENT and the Coroner.

[redacted] noted that [redacted] and [redacted] attended from CIB. The IDENT officers were [redacted] and [redacted]

[redacted] indicated that he was not in close proximity when the body was removed from the river by a CIB officer and [redacted]. Shortly thereafter, he and [redacted] were cleared from the scene.

[redacted] believed that he had already left the scene by the time the deceased was identified as SD. He said there was no mention of the fact that SD was Indigenous, other than the mention of his name.

[redacted] indicated that while he was at the scene there was no speculation about what happened to the deceased. He said that that they would let the evidence lead them. [redacted] did not perform any follow up duties with respect to the continued investigation.

Respondent Officer 2 – [redacted]

[redacted] *provided a recorded interview with the OIPRD on December 1, 2016. The following is a summary of the relevant portions of the interview.*

[redacted] has been a police officer since April 2007. He joined the TBPS in April 2009. At the time of the interview he was assigned to Uniform Patrol.

On October 19, 2015, he was dispatched with [redacted] to Carrick Street and Waterford Street for a possible deceased male. They arrived on scene at 9:32 a.m. [redacted] and paramedics were present. [redacted] advised him that a male was located in the river and had been pronounced deceased by paramedics.

[redacted] observed the body face down by the riverbank, partially in the water. He spoke briefly to Civilian Witness 1, the paramedic who pronounced the male deceased. Civilian Witness 1 told him that he had slightly turned the body to confirm that the male was deceased and then he placed him back in the position he was found.

[redacted] was told that an Ontario Health Card in the name of FF had been located in the area. He ran the name through CPIC and learned that FF had several outstanding warrants for his arrest.

[redacted] took a notebook statement from PP, the 911 caller. PP advised him that he was walking his dog along the pathway when he observed a male at the edge of the river in the weeds. He believed the male was deceased and immediately called 911. After taking PP's statement, [redacted] contained the scene with police caution tape and waited for the CIB, IDENT and the Coroner to arrive.

When [redacted] and [redacted] arrived on scene, [redacted] informed them of what he was told by PP and Civilian Witness 1. He further advised that he had run the name FF on CPIC and advised them of the results.

[redacted] remained on the scene, providing scene security and preventing people from using the pathway adjacent to the river. He was present when the Coroner arrived, but did not overhear any conversation about what happened to the deceased. He said that he was not aware, at the time, that the deceased was Indigenous.

[redacted] said that he later learned that the deceased was SD. He was not familiar with the name as he had no previous dealings with him.

[redacted] said that he completed a supplementary occurrence report detailing his interaction with PP and Civilian Witness 1. He had no further involvement in the investigation.

Respondent Officer 3 – [redacted] *provided a recorded interview with the OIPRD on December 1, 2016. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS for 10 years. On October 19, 2015, he was assigned to Uniform Patrol. He is currently assigned to the CIB.

On October 19, 2015, [redacted] heard a call over the radio about a person that had been found in the river. He attended the area of Carrick Street and Waterford Street. When he arrived on the scene, [redacted] and [redacted] were there. He noticed the body of a male in the water just off the riverbank on the north side. He observed that the deceased was face down, wearing jeans, running shoes, a brown jacket and a black belt. Paramedics were on scene and had pronounced the male deceased. At that point, a sergeant was requested to attend the scene.

[redacted] assisted in securing the scene and setting up the perimeter scene tape. When CIB attended the scene, [redacted] asked him to speak to an individual known to police, who happened to be in the area. He determined that the individual had no knowledge of the matter.

Once the Coroner, Civilian Witness 2, arrived on scene, [redacted], along with [redacted] and [redacted] removed the deceased from the water. The deceased was placed on his back and at that point, [redacted] recognized him as SD.

Although [redacted] recognized the deceased as SD, his identity was not positively confirmed at that time. He said that he was not involved in any further identification efforts to verify the identity.

[redacted] described some of his previous interactions with SD. He advised that he had worked in Patrol Zone 4 for seven years and had numerous interactions with SD related to liquor infractions and public intoxication. He indicated that SD was "*sometimes violent or aggressive"* depending on the situation. [redacted] said his most recent interaction with SD was approximately two years prior.

[redacted] indicated that he spoke to a potential witness named KK who advised him that the previous night he had been in the area and had seen approximately five to seven Native Canadians, one female and the rest males, in the vicinity where SD was found. KK had seen two males pushing each other, but was unable to provide a description of either man. He said the he avoided the group because they all appeared intoxicated.

[redacted] took a notebook statement from KK. He could not recall if he relayed the information from KK to one of the CIB officers on scene and stated that there was no reason why he would not have done so. He confirmed that the CIB had arrived on scene prior to him speaking with KK.

[redacted] filed a supplementary occurrence report that contained KK's statement. However, he had no knowledge whether the report would have gone into SD's investigative file or if the information would have been relayed directly to the lead detective. [redacted] was not aware if anyone had followed up with KK regarding his statement.

While at the scene, [redacted] said that he did not hear any discussions regarding the likely circumstances of how the deceased ended up in the water. He had no knowledge of whether the death was being characterized as suspicious or not. His stated that his role was minimal once the CIB officers arrived.

Respondent Officer 4 – [redacted] *provided a recorded interview with the OIPRD on January 18, 2017. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS since December 2002. He is currently assigned to Uniform Patrol and has acted in the capacity of Sergeant when needed. On October 19, 2015, he was in the capacity of [redacted]

At approximately 9:40 a.m., [redacted] attended Carrick Street and Water Street in regards to a call about a body on the riverbank. When he arrived on scene, uniformed constables had sealed off the area and were speaking with potential witnesses. He oversaw what they were doing and ensured that CIB, IDENT and the Coroner were called.

[redacted] said that he was there in a supervisory role and had the authority to oversee CIB and direct the officers at the scene. He did not enter the area and remained outside of the perimeter tape. He stated that everything appeared as though it was being handled well. He was aware that witnesses were being interviewed and that cameras in businesses in the area were being reviewed.

[redacted] said that there were no discussions at the scene about what possibly happened to the deceased and how he came to be in the river. He said that CIB were investigating the matter and would follow up as required.

When asked if he was aware of the information received by witness KK about a number of Indigenous men and one woman who were seen the night before embroiled in an altercation, [redacted] said that he did not recall receiving that information.

He indicated that [redacted] was under his direct command and if he had relayed any information about an interview with a witness, it would have been very brief and in the course of him updating him on what was going on. He further indicated that they all worked as a team and he was 100 per cent sure that [redacted] would have talked to CIB and relayed all pertinent information to them at the scene.

[redacted] said that he had no involvement in identifying the deceased. He noted that the Coroner arrived at 10:42 a.m., and the funeral home arrived at approximately 11:00 a.m. He departed the scene shortly after the deceased was removed from the water as there was no longer a need for police presence.

Respondent Officer 5 – [redacted]

provided a recorded interview with the OIPRD on December 1, 2016. The following is a summary of the relevant portions of the interview.

[redacted] has been a member of TBPS since February 1999. She is currently a Detective Constable in IDENT.

On October 19, 2015, she was partnered with [redacted] As IDENT officers, they were advised by the communications centre that they were required at the scene of a sudden death.

When they arrived on the scene, [redacted] noted that uniformed officers and CIB were already there. She did not recall if paramedics were on scene and was not aware if any potential witnesses had been interviewed. She spoke to [redacted] who directed her to the location of a deceased male in the river.

[redacted] observed a male face down in the river. There were some items scattered about the bank of the river. She and [redacted] walked along the riverbank to see if there was any other evidence or items. Photographs were taken of the scene and all of the items on the riverbank. She indicated that all evidence was marked, photographed and collected.

When the Coroner arrived, the body was removed from the river and examined. [redacted] took photographs of the deceased before the body was placed in a body bag.

When the body was removed from the water, some officers recognized the deceased as SD. She said there was no discussion about the fact that the deceased was Indigenous.

[redacted] said that she did not make any assumptions about may have happened to SD. She said that the riverbank was a hill leading into the river. It was not straight down and someone could walk down it comfortably. SD was located right at the shoreline. [redacted] said that she did not note the flow or depth of the river, but suggested that the flow and depth changed with the season and weather conditions.

[redacted] advised that no video was taken of the scene. She said that IDENT only took video of scenes believed to be homicides.

After the Coroner completed an examination of the body he made the decision, in consultation with CIB, to release the scene.

[redacted] advised that she did not attend the autopsy and her involvement ended after she secured the exhibits she collected at the scene.

Respondent Officer 6 – [redacted] *provided a recorded interview with the OIPRD on December 1, 2016. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS since August 2009. He is currently assigned to IDENT and has been in that unit since 2013.

On October 19, 2015, he was partnered with [redacted] and they responded to a call of a sudden death of a person in the river at Carrick Street and Waterford Street.

They arrived on scene at 9:55 a.m., [redacted] said that he observed the body of a male at the edge of the riverbank on the north side. The body was face down and the deceased was wearing a tan jacket, blue jeans, a black belt and white shoes. He noted that the weather was mild and slightly overcast. The river was slow moving and very still at the shoreline.

[redacted] noted that there was a bike path approximately seven paces north of the river edge. There was uneven ground and a downhill grade leading to the water. He did not measure the grade, but observed that it was moderately steep, yet walkable.

He and [redacted] began to mark exhibits on the ground that they thought might have significance. They collected 10 exhibits: a black ball hat; an Ontario Health Card that bore the name FF; two cigarette butts; two black gloves; a pack of matches; crunched up paper; a piece of paper torn from a phonebook; and a piece of rolled up toilet paper. [redacted] took photographs of where the exhibits were located and the entire area where the body was discovered.

At 10:43 a.m., the Coroner arrived on scene. The body was removed from the water. At that time, a zip lock bag was found near the deceased's head. Inside the zip lock bag was an Ontario Health Card belonging to SD, two winner's circle cards, an air miles business card, a $10 phone card and a handwritten note.

Once the body was placed on the bank and rolled onto his back, [redacted] observed the deceased to be a Native Canadian male. One of the officers on the scene recognized him as SD.

[redacted] assisted the Coroner with examining the body by lifting up SD's clothing. There were no visible signs of injury on SD's face, head, hands, chest or back. Once the initial observations were complete, SD was placed in a sealed body bag. The Coroner advised that an autopsy would be conducted.

[redacted] said that he made no determinations of how the body could have ended in the water. There was no video taken of the scene because it was not considered suspicious. *"It was not believed to be anything more than a drowning."* He was not sure who made that determination, but believed it was the Coroner. He thought it was based on the condition of the body, along with the fact that there was nothing out of the ordinary at the scene. He advised that if it had been a suspicious scene, they would have taken video and held the scene until after the autopsy in the event they had to return to look for further evidence.

[redacted] said that IDENT assisted to positively identify the deceased as SD. However, he was not sure what further avenues were used to confirm his identity. He indicated that they would have taken a fingerprint at the autopsy.

[redacted] said there were no discussions about the fact that the deceased was Indigenous. It was not an issue and only recorded as a description in his notes. He went on to say that the fact that the deceased was Indigenous absolutely did not affect what they did and it would not be done differently if the deceased was not Indigenous.

[redacted] processed the scene and maintained continuity of the exhibits. He provided the personal identification found at the scene to property and storage for the family to pick up. He did not attend the autopsy and had no further involvement in the investigation.

Respondent Officer 7 – [redacted]

[redacted] *provided a recorded interview with the OIPRD on January 11, 2017. The following is the relevant portions of the interview.*

[redacted] has been a member of TBPS for over 16 an half years. His current role is as [redacted] in the Uniform Branch and acts in the capacity of [redacted]. On October 19, 2015, he was [redacted] in the CIB.

[redacted] heard the report of a sudden death over the radio. With those types of calls, he would attend the scene. He stated that normally the detectives would not proceed into an area until IDENT had assured them that the scene was contained and secured and CIB would not contaminate any potential evidence.

When he arrived at the outdoor scene located at the bottom end of Carrick Street and Waterford Street, IDENT and uniformed officers were there. The area had been cordoned off with police tape. He did not enter into the scene, but from his vantage point he observed a deceased person in the water.

[redacted] said that paramedics were no longer there as they had pronounced the person deceased and no life saving measures were undertaken. He said that as the IDENT officers did their work, he, [redacted] and [redacted] waited for the Coroner to attend.

[redacted] described the area as a regular concourse for foot and bicycle traffic. He said that there was the potential for lot of evidence that might not necessarily be a part of the investigation. It was the IDENT officers' responsibility to collect all of the pertinent evidence. If he noted something he felt was pertinent to the investigation, he would advise the officers and they would collect the evidence accordingly.

[redacted] said that while IDENT collected evidence, it was pointed out to him that there was an identification card located on the riverbank. As the deceased was discovered face down in the river, [redacted] thought that the identification possibly belonged to the deceased.

While he waited for the Coroner to arrive, [redacted] noted that the media were at the scene. He contacted [redacted] and the TBPS executive officer, Civilian Witness 3, and advised them. He also noted that there was a minivan on scene with a family looking to see if the deceased was one of their family members. The information that the police had recovered a body in the McIntyre River was on social media and the family was concerned that the body in the river was a member of their family.

When the Coroner arrived on scene, he requested assistance to remove the body from the river. [redacted] and [redacted] assisted in removing the body. Once the body was removed from the river, one of the officers on scene said that he believed the deceased was SD. [redacted] was familiar with the name as he had dealt with him several years prior, but was not able to recognize him on sight. A zip lock bag was located next to the body that had identification documents belonging to SD. [redacted] said that they were not 100 per cent sure that the deceased was SD.

He said that although some officers had identified him, he preferred fingerprints to make a positive identification. At the autopsy, they would obtain fingerprints that would be compared by IDENT officers to confirm the identity.

[redacted] said that the body was examined by the Coroner. He observed the Coroner lift up his shirt and examine him. After the cursory examination, the Coroner indicated that there did not appear to be any trauma to the body. He requested that the body be taken to Thunder Bay Regional Hospital for an autopsy. [redacted] stated that he had seen a lot of dead bodies and the ones that met with foul play showed foul play. He said that, in fact, he could not think of one that did not.

[redacted] said at that point, the case became a Coroner's case and he did not have the same supervision that he would have as a Major Case Manager had the death been deemed a homicide. He explained that based on the Coroner's determination that there were no obvious signs of trauma; the death did not appear to be as a result of foul play or suspicious circumstances. He said that he would assist the Coroner if the Coroner required him to do something. He added, *"Essentially, when it's a Coroner's case we do whatever the Coroner tell us to do at that point."*

Civilian Witness 3 attended the scene. [redacted] advised him that a male was recovered from the river, but they were not 100 per cent sure of his identity. He advised that he also spoke to the media person who was at the scene, but could not recall what was said. [redacted] said that he did not remember what conversation he had with any of the officers that were on scene. He said that he made a note of the person who initially found the deceased, but could not recall if it was [redacted] or [redacted] who provided him with that information.

[redacted] said that while on scene there was a male who had approached them. He tasked [redacted] with speaking to the male to ascertain if he had any information. The male was just passing through and did not have any information about the deceased or what might have possibly happened.

According to [redacted], he was never provided with information from [redacted] about two males who were engaged in a conflict by the river where the deceased was found. He said that he could not speak specifically for [redacted] or [redacted] but did not recall them mentioning that information either. He did not believe that information was passed on.

[redacted] said that although there was no evidence at the scene that indicated that there was any type of foul play, he wanted to speak with the person whose personal identification was found on the riverbank. He said that they had no information that SD had been with anyone else at the time.

[redacted] said that it was around the noon hour and they were getting a lot of pressure from the media to put some information out. Civilian Witness 3 sent him the press release which he approved. He said the email was also sent to [redacted]

[redacted] was asked about the second press release in which the incident was deemed *"non-criminal."* He said that he did not recall that press release and could not confirm if it was sent to him prior for approval.

[redacted] reported that at approximately 2:30 p.m., he was notified that SD's next of kin had called police and wanted to report him as missing. He advised the officer to take the missing person report because he still had not positively identified the deceased as SD. He was advised that IDENT took photographs of tattoos on the deceased and that SD's tattoos had been noted on the police database.

[redacted] acknowledged that tattoo identification may not be 100 per cent like a fingerprint, but he could be 99 per cent sure. He said that he could not allow the next of kin to think that their relative was missing when they were in fact deceased.

[redacted] tasked [redacted] and [redacted] to attend the next of kin's (Civilian Witness 4), residence to notify the family that they believed the body found in the river was SD.

[redacted] said that when [redacted] and [redacted] returned, they advised him that they had notified Civilian Witness 4, but did not mention that there were several people at the residence who were in the company of SD the night before he was found deceased.

[redacted] said that [redacted] and [redacted] made no attempts to interview anyone who was at Civilian Witness 4's house because they were advised that SD was left on the riverbank with FF. Based on that information, they determined that they were not the last people to see him.

[redacted] reported that [redacted] and [redacted] attended FF's father's residence, where he was known to reside. FF was not there and they left contact information with his father to have him call them. The officers said that they were aware that there was a warrant for his arrest and felt that was a reason why he did not want to contact them.

[redacted] said that he put FF's name on a MOB (Major Occurrence Bulletin). He explained that when a person was *flagged* an insignia would appear on the computer to advise an officer that the person needed to be spoken to by police.

[redacted] stated that they never heard from FF and that concluded their investigation. No further attempts were made to contact him. He said that despite the fact that there was a warrant for his arrest, they (the police) were more concerned with criminal investigations than to look for people with outstanding warrants. He stated, *"That's not my job. I've got other stuff to do."* [redacted] believed that FF avoided contact with the police so he would not be placed in custody.

On October 21, 2015, Complainant 1, accompanied by Civilian Witness 6 and their aunt attended TBPS. [redacted] said that he was familiar with Complainant 1's name and knew that he had a *"very tumultuous"* relationship with TBPS in his past. Complainant 1 advised him that he had heard through Facebook that SD was deceased. [redacted] said he was a little surprised because he expected that Civilian Witness 4 had notified SD's extended family that he was deceased.

[redacted] said he spoke to the family and advised them what police knew at that time. He informed them were SD was found, that they were waiting to talk to one witness and that the Coroner did not believe foul play was involved. He further informed them that there was going to be an autopsy. If the autopsy revealed that there was some sort of foul play, then they would investigate it as a criminal matter.

[redacted] said that Complainant 1 was immediately on the offensive. At one point, he stated that he was going to get a lawyer. [redacted] said that he told him that would be fine. He questioned why he needed a lawyer and thought that he was more concerned with what the police were doing and not the death of his brother. He said that he was used to family members not being very happy with police because they were the bearers of bad news.

[redacted] said he concluded the meeting by advising them that he would let them know when the autopsy would be conducted. He provided them with his contact information and concluded the meeting.

[redacted] said that later that afternoon he saw Complainant 1 and his family by the river. He indicated that he was not that familiar with First Nations' culture, but he knew from previous investigations that the family would go to the location where their next of kin passed away. He decided to show them where SD's body was found.

At that time, he informed Complainant 1 that he was not certain how SD ended up in the river, but indicated that he may have stumbled down the embankment and rolled into the water. He said that he was not sure what happened and did not make any definitive claims to the family.

[redacted] stated that by the time the autopsy had taken place, the pathologist had determined that the cause of death was drowning. They were still waiting for the toxicology report to determine if alcohol was a contributing factor. Based on that information, the case remained a Coroner's investigation and [redacted] said he had numerous other incidents that he was investigating.

Approximately one month after the first meeting, Complainant 1 returned to the police station with a private investigator. [redacted] indicated that he was not going to speak to a private investigator about the case. He stated, "*I'm not going to speak to any private investigator about a case, it's not his information. It's private information and I'm not going to speak to him about it, so I never called him back.*"

On November 24, 2015, he met with Complainant 1 again. At that time, Complainant 1 asked why had not returned his phone call. [redacted] explained that he had the contact information for the private investigator, but decided against calling him. Complainant 1 then requested information about the investigation and [redacted] told him that he would have to file a Freedom of Information (FOI) request in order to obtain any documents.

[redacted] said that their second encounter became heated. He said that Complainant 1 told him that the police did not do anything for First Nations People. [redacted] said that he was *"highly insulted"* because he worked on a lot of homicides where both the victim and the accused were First Nations. He said he would never fail to do his job because of somebody's race or creed or anything else like that.

> *"Well, I started getting a little annoyed that he was accusing me of this. I'll say that. I indicated to him that the previous year, Ten out of eleven homicides were First Nations people involved. That was an obvious exaggeration, but it was a majority. I said to him that we investigate those and we've solved all but one."*

It was not until sometime in March 2016, when [redacted] contacted [redacted] to inquire about the investigation. At that time they learned that FF had been in custody on a least two separate occasions. [redacted] said that it was his understanding that the MOB was still active, but due to some system errors, they were never notified when FF had been arrested.

FF was interviewed and asked what he recalled about October 19, 2015. More specifically, he was asked if he recalled anything that happened by the river at that time. FF informed the officers that he did not recall much about what happened. He advised that he received information from his father that officers had attended his residence. When he called the police station, he was told that the officer was off duty.

[redacted] said that after the interview with FF, he was no longer involved in the investigation. A complaint had been filed and the investigation was to be continued by other investigators. He had no contact with the new investigator assigned to the case.

Prior to the complaint being initiated, [redacted] was not aware that SD's debit card had been used after his death. He did not believe that the debit card had any relevance to the investigation.

[redacted] said that the police had a lot of pressure placed on them by their leadership to indicate that they are doing their work and not engaged in *"moonlight tours."* He said for the last number of years he was aware that they need to be extremely vigilant when doing their jobs and also be aware of the political pressures.

[redacted] believed the officers at the TBPS were *"compassionate people overall"* that did their jobs no matter what the race of the deceased person. He was investigating a sudden death and that was all it came down to. The fact that the deceased was a First Nations person was not going to make him do more or less work.

He said that there was no indication of how SD ended up in the water. There was nothing to indicate that he was pushed into the water or that something was done to him, other than he was very intoxicated.

[redacted] said that he did not like having his abilities questioned by Civilian Witness 7. He rejected the implication that he had done a *"shoddy investigation"* because SD was a First Nations person. He stated, *"When I think of my record up to this point, and after that point, it has shown that I don't show any type of bias or anything like that. That's what it comes down to."*

[redacted] was insulted that Complainant 1 accused him of having a bias. He said that, due to the social issues in Thunder Bay, the majority of death investigations, especially the homicides, involved First Nations people. He worked as hard on those cases to try to get closure. If it was a homicide, he hoped to arrest and convict the perpetrator.

[redacted] said that he had one unsolved homicide that was a young First Nations male. He was in contact with the father throughout the investigation and believed he had a good relationship with the family. He indicated that for him, *"it has never been an issue about race. It's a matter of family of the victim. The family are also victims and we are trying to get some closure for them."*

[redacted] stated that he believed that all of the TBPS officers did good, hard work regardless of the victim. Ultimately they dealt with people who were socially and economically depressed, who might have substance abuse issues and were not the *"pillars of society,"* but the police did their best work. He stated, *"Whether they're First Nations or Caucasian or any other type of race, we do our work based on a want to do what's right"* and anything else is insulting.

Respondent Officer 8 – [redacted]

[redacted] *provided a recorded interview with the OIPRD on January 11, 2017. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS for 16 years. He was recently promoted to the rank of [redacted]. On October 19, 2015, he was [redacted] with the CIB and reported to [redacted]

On that date [redacted] was in court when he heard the call regarding a body in the river. He attended the scene to offer his assistance. When he arrived, IDENT officers were documenting the scene. At that time, the body was unidentified and they were waiting for the Coroner to arrive. Paramedics had already departed the scene after confirming that the person was deceased.

When the Coroner arrived, [redacted] entered the scene and assisted with processing and documenting the scene. There was no forensic evidence from the scene that pointed to a particular theory of how the deceased ended up in the river.

[redacted] did not speak to [redacted] at the scene and he did not recall being advised about a group of Native gentlemen and one female involved in an altercation the night before.

Once the body was removed from the water the Coroner made his observations. There was some suspicion that the deceased was SD. However, they needed to positively identify the body before they could notify the next of kin. [redacted] said that after he returned to the station, he received information that Civilian Witness 4, the common-law spouse of SD, had called in to report SD as a missing person.

The police determined that there was enough positive identification at that point to notify the next of kin. [redacted] detailed him and [redacted] to attend Civilian Witness 4's apartment to notify her of the SD's death.

According to [redacted], [redacted] was the [redacted] in the case and would direct the other officers. He was not the *"lead investigator"* as this did not fall under the major case model. He said that sudden deaths did not fall under the major case model; however, suspicious sudden deaths did. The manner of death would be determined by the pathologist.

At that time, there was nothing that pointed to the death as suspicious. The body had been found in the river and the police did not know how it got there. There were no witness statements or other evidence, such as drag marks indicating the body had been dragged into the river that would have raised any suspicions or alarms. They did not know one way or the other whether it was a criminal event.

[redacted] said that when they attended Civilian Witness 4's residence, he did not enter the apartment as there were a large number of people already there. He relied on [redacted] for notes as there was a heated domestic situation in the hallway which he thought might require his intervention. They were advised that a group had been drinking the night before with SD behind the Shoppers Drug Mart at approximately 7:00 p.m. The group eventually dispersed and SD was left passed out on the riverbank with FF.

[redacted] spoke with them and took notes of the conversation. There was no thought of bringing any of the people in for formal interviews because they were conducting a sudden death investigation with no indication that it was suspicious or criminal. Again, it was not a major case. There was nothing indicating it was criminal. He stated that if they had any information pointing to SD's death being criminal, they would have launched into a criminal investigation.

[redacted] was aware that FF's identification had been found at the scene. On October 20, 2015, he and [redacted] attended FF's residence to speak to him about the incident. He was not home. [redacted] left his card with his father who indicated that he would pass it along when he saw his son and have him contact police.

[redacted] believed it was that same day that [redacted] put FF's name on a BOLO (Be On the Look Out), and a MOB. A name placed on a BOLO would be read out at shift briefings for five days to alert officers to be on the lookout for that person. The name would also be flagged on NICHE in TBPS's internal system. No further attempts were made to find FF. He stated that if it had been a major case (that is, a homicide), the police would have followed up. They still needed to speak with FF, but there was no urgency, as it did not relate to a criminal matter.

On October 21, 2015, [redacted] and [redacted] met with Complainant 1 and his family. They wanted to know why they were not notified of SD's death. They informed him that they found out through social media. [redacted] let them know that the deceased's common-law spouse was notified as his next of kin.

The family also called into question whether SD had been killed. [redacted] did most of the talking and said that there was nothing to indicate that. Once the autopsy was complete, if there was new information from that or from any other source pointing towards criminal activity, they would launch an investigation and they would look into it further. [redacted] did not hear [redacted] say that the investigation was effectively completed or that no further work was to be done.

[redacted] did not believe that [redacted] advised SD's family that his theory was that SD passed out unconscious and simply rolled nine or 10 feet down the riverbank into the weeds and drowned. What was said was that they do not know how he ended up in the river and that was one of the possibilities. According to [redacted] stated, *"He may have rolled in. We don't know. We may never know how he ended up there."*

[redacted] said that he had no involvement in the media releases. He indicated that the October 20, 2015 (second) media release deeming the death as *"non-criminal"* was not reflective of the state of the investigation as that had not been determined yet. Also, the autopsy report could point them in a different direction if it came back, for example, with fresh bruising.

On March 24, 2016, [redacted] received a call from [redacted] asking him about FF. As earlier indicated, FF had been on a BOLO and MOB bulletin. When he learned that FF had not yet been interviewed, [redacted] stated, *"That's a problem."* [redacted] said he had no idea what he was referring to and [redacted] did not give him any direction at the time. [redacted] told [redacted] that he should speak with [redacted] about the matter. He said in his 16 years of policing, he had never received a call from [redacted] at home. He felt as though [redacted] was *"poking"* them and he did not feel that he needed to be told that he had to follow up with FF if he was in custody.

When [redacted] contacted [redacted], he confirmed that FF was still on the MOB. He further learned that FF had contact with officers on a few occasions, but CIB was never notified.

On March 28, 2016, [redacted] and [redacted] attended the district jail to interview FF. He said that FF recalled very little besides being intoxicated and having a verbal argument with his brother, CC that night. He did not recall specifically drinking with SD. He remembered that he left and walked to JJ's house. That evening [redacted] attended the address given for JJ, but none of the occupants knew who JJ was.

[redacted] indicated that was his last involvement with the investigation and that he had not spoken to the new investigators assigned to the case.

Respondent Officer 9 – [redacted]

[redacted] *provided a recorded interview with the OIPRD on December 2, 2016. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS since 2006. At the time of the interview he was assigned to the CIB.

On October 19, 2015, he attended the scene of a sudden death with [redacted] When they arrived, [redacted] and the [redacted] were on scene.

[redacted] said that he could see a body in the water at the bottom of the hill. He noted that there was a downgraded slope toward the river. He did not notice anything that stood out from the scene that was forensically significant. He collected information from the officers at the scene and was told that identification in the name of FF was found on the riverbank. He was also advised that [redacted] spoke to the 911 caller, PP, who had discovered the body.

[redacted] was unaware of any reports regarding witness KK. He was not familiar with the name. He said that he would have expected a uniformed officer to convey that information to CIB at the scene.

At 9:56 a.m., IDENT officers arrived on the scene to perform their duties. [redacted] canvassed the local businesses in the area and looked for external cameras. He did not note any cameras. In his experience, if he could not see an external camera, it meant that it most likely did not exist. He said that he then stood by and waited for IDENT to finish and for the Coroner to arrive.

[redacted] said that the executive officer that dealt with a lot of the media releases, Civilian Witness 3, arrived at the scene. He was unsure what role he played and stated that it was the first time he seen him at a scene.

[redacted] said there were no discussions as to who the lead investigator would be. [redacted] was the boss and would usually point out who would be the lead. They did not really have a system.

The Coroner arrived on scene at approximately 10:45 a.m. [redacted] assisted in removing the body from the water under the direction of the Coroner. The body was placed on the riverbank and turned over to try to identify him. A few officers immediately recognized that the deceased was SD.

[redacted] recalled his last encounter with SD. He said he had come across SD passed out and unconscious in the parking lot of a strip mall. He went to check on him and woke him up. After determining that he was heavily intoxicated, he called a road unit to assist SD. He recalled that most of his encounters with SD involved intoxication.

When the Coroner examined SD's body, no obvious signs of trauma were identified. There was nothing obvious other than the fact that SD was deceased. His body was then placed in a bag and tagged.

[redacted] stated that in a sudden death investigation, the police relied on gathering information and speaking to the witnesses. IDENT also went through the scene. The Coroner would be the lead until the case became suspicious. At that point, they had not been notified of anything that showed it to be a suspicious death. If information came along that took it in a different direction, they would take that very seriously and investigate. There was no determination initially or assumption respecting whether a death was suspicious or non-suspicious. They go into investigations with an open mind. A lot depended on the autopsy as well. [redacted] agreed that a more appropriate term would be *"undetermined"* until the investigation was completed.

When [redacted] returned to the parking area, he noted that a concerned woman had pulled up in a vehicle. He approached her in the event that she had information relevant to the case. The woman told him that she was concerned that the body they recovered was her son. She had heard through social media that somebody had been found. [redacted] said that because he knew the body was SD, he told her that it was not her son. She was relieved and drove away.

According to [redacted] there could have been discussions about possible scenarios as to what had happened to SD, but he could not recall them. Regardless, the discussions would not have amounted to a working theory.

[redacted] returned to the station and learned that a missing person report had been filed for SD. Although, he knew visually that the deceased was SD, they waited for confirmation from IDENT through comparison of his tattoos to positively identify him.

At 3:10 p.m., he attended Civilian Witness 4's residence with [redacted] and notified her about SD's death. He informed her that SD had been found in the river and that he was very sorry for her loss. He then asked several people who were in the residence if anyone knew what had happened and when they had last seen SD.

[redacted] was advised that a group of them had been drinking together the previous evening. The group eventually dispersed and SD and FF were left passed out on the riverbank. They called in the missing person report on SD as they heard somebody had been found in the river and that was the last place they had seen him.

On October 20, 2015, [redacted] went to FF's last home address and spoke to his father. His father indicated that he had not seen FF for a couple of days even though he was court mandated to reside there. [redacted] gave him his business card and asked him to tell FF to call the police as soon as possible.

On October 21, 2015, [redacted] met with Complainant 1 and his family. [redacted] and [redacted] were present for the meeting. He said that he was in and out of the meeting. He remembered that [redacted] spoke to Complainant 1 about the case and explained the Coroner's finding and updated him on the status of the investigation. Complainant 1 was not satisfied with the explanation and mentioned that he wanted an inquiry. He could not recall what [redacted] told him. He said that at no time did Complainant 1 express concerns about his brother being dealt differently because he was Indigenous.

[redacted] only became aware in late 2016, that the case had been re-assigned. He advised that a matter was never closed as new information could come in at any time. He was not aware at the time why the investigation had been re-assigned, but subsequently found out it was because of the present complaint. [redacted] had no further involvement in the investigation.

Respondent Officer 10 – [redacted] *provided a recorded interview with the OIPRD on January 13, 2017. The following is a summary of the relevant portions of the interview.*

[redacted] has been a member of TBPS for 21 and a half years. She is currently [redacted] for Uniform Branch. On October 19, 2015, she was [redacted] in the CIB.

On that date she was in training and was involved in the initial investigation into SD's death. Her first involvement with the investigation was when she was briefed by [redacted] on October 20, 2015. As his immediate supervisor, he updated her on the status of the investigation. She, in turn, would update [redacted] There were no regular updates on the investigation as there were many investigations ongoing. She was updated only when something happened. [redacted] told her that the death did not appear criminal. He informed her that it would be a Coroner's investigation and there was nothing to indicate foul play.

[redacted] received a subsequent update from [redacted] after the autopsy. She was advised that there was no anatomical cause of death, and that they wanted to speak with FF. She did not remember the date of the update.

[redacted] told [redacted] to put FF on BOLO so that if he had any interactions with police, they would be able to speak to him. She knew this was done. She did not give any further directions to [redacted] nor did she have any concerns with the investigation. She recalled that officers eventually spoke to FF, but believed it was in the New Year.

[redacted] said that she received a phone call from an Indigenous leader, LL on October 20, 2015. LL was not related to SD and asked her questions about how the case would be handled, if the next of kin had been notified and if there was going to be a public release. [redacted] gave her no information about the investigation other than at that time it did not appear to be criminal. LL was not pleased as she wanted to know who the deceased was and wanted more information about the actual incident.

With respect to the media release, [redacted] could not recall if the first media release was sent to her. She remembered receiving the second media release, but was unsure if she commented on it. She advised that the distribution list depended on the situation and could include the investigator, herself and usually the Inspector, but that could change. Comments would be made and whoever approved the release would be dependent on the case. When the final release was sent out, it would go to her as part of the police broadcast along with media and everyone else.

[redacted] said that she could see that there was difficulty with the second media release that had SD's name, as well as the statement that the police deemed his death as *"non-criminal."* She said the language used could have allowed people to believe that the police were no longer investigating the matter. She went to say that although there was no indication the death was suspicious, the investigation was ongoing and the autopsy had not yet been completed.

[redacted]felt it was essential for the investigators to speak to people who were with SD the night before he was found, including FF. An autopsy would not reveal, for example, if SD had been pushed into the river and she expected that the investigators would take formal statements from people to find out whether there had been any altercation between SD and FF.

[redacted] was not aware of the information that [redacted] obtained from the witness KK. She recently read the report and would have expected that the investigating officer would have read the supplementary occurrence report filed by [redacted] and followed up on it.

In March 2016, she had a conversation with [redacted] who advised her that the Deputy Chief intended to co-manage or co-direct the CIB. He felt there was an issue with how investigations were being completed and was concerned about the report the CBC did on the SD investigation. She was told that [redacted] wanted to have weekly meetings, but that never occurred. Also, there was no specific file pointed out to her that was deemed problematic.

Shortly thereafter, she was advised that there was a complaint and the initial investigators were removed from the case and not permitted to deal with it anymore. However, by that point that officers had interviewed FF and spoke to others who had been with SD. She indicated that she was satisfied with the investigation at that time.

[redacted] said that when they received the toxicology report it indicated that SD had a high level of alcohol in his system. The Coroner's report indicated that his death was due to drowning. In her view, it was a natural or accidental death. She did not recall if she ever had a conversation with [redacted] in which he expressed to her that the case was closed from his perspective.

[redacted] said that she later met with the Deputy Chief to discuss the SD investigation. The Deputy did not want their people *"tripped up"* by anything so he wanted them to audio interview all of the people on Civilian Witness 7's list and to follow up on SD's financials. [redacted] felt that the follow-up work was being done for a combination of reasons: as part of an appropriate investigation; and because of what had been referred to in the ISN report.

[redacted] stated that the investigators who had worked on the SD investigation had worked on *"numerous deaths of Aboriginals, Caucasians, Hispanic, and African-Americans and they do an excellent job."* Although [redacted] thought that the media release could have been done differently, she believed that the conclusion they arrived at, indicating that the death was non-criminal, was accurate.

Respondent Officer 11 – [redacted]

[redacted] *provided a recorded interview with the OIPRD on January 11, 2017. The following is a summary of the relevant portions of the interview.*

[redacted] has been with TBPS for almost 32 years. He had been [redacted] of the CIB since 2009, and had recently taken on the role as [redacted] as of [redacted] 2017. He [redacted], and subsequently [redacted] before the completion of the OIPRD investigation.

As [redacted], he served as management for the CIB. The Detective Sergeant reported to him directly. The Detective Sergeant managed the day-to-day activities and the investigations. [redacted] was the case manager for all of the major case investigations which included death and sudden death investigations. Report approval was at that level. Detectives reported to him as well as detective constables.

[redacted] role involved oversight, managing the budget and making sure officers were properly trained and the right officers with the right aptitudes and background were filling the roles of investigators. CIB also did SIU liaison, OIPRD investigation liaison, complaints, work harassment complaint investigation for the Chief, city council presentations, Police Services Board presentations and other things.

[redacted] had 12 general investigators who would investigate a sudden death. It would not be unusual for a detective in his unit to be investigating seven homicides at a time. [redacted] believed there had been 43 homicides since 2009. Only two were unsolved which indicated a very high clearance and conviction rate.

On October 19, 2015, [redacted] was informed almost immediately after the body was found. He was informed by [redacted] via email that there was a death and identification on the riverbank belonging to FF. [redacted] also had a telephone conversation with [redacted]. [redacted] then sent an email to the Chief and Deputy that stated, "*Gents deceased has been ID'd as SD, 41 years of age, FF's ID was nearby, no sign of foul play, Coroner's still at the scene."*

[redacted] could not recall the exact conversation and how he was told there was no sign of foul play. He believed he would have been informed that observations at the scene showed no obvious signs of a homicide. One of the concerns they had was whether they had a homicide and a major case or not.

[redacted] had no further involvement with managing the direction of the investigation. The lead investigator was [redacted]. The case was managed by [redacted] who was [redacted] immediate supervisor. [redacted] acted as [redacted] and would fill in, as he did on October 19, 2015, as [redacted] was training that day. [redacted], in his role as [redacted] played an administrative role and would have passed information to [redacted]

[redacted] updated [redacted] on all investigations, particularly deaths. [redacted]could not remember any specific dates he was updated, but believed that he was.

[redacted] believed that [redacted] submitted a report in March 2016, when the toxicology report was returned and concluded, up to that point, based on the evidence and the totality of the investigation, that SD's death was a drowning and there was no foul play.

[redacted] was on medical leave from March 2016, to November 28, 2016, and was not involved in moving the investigation from [redacted] to [redacted]. He had not been briefed about the reason for that since he returned to work. He chaired promotional interviews for two weeks when he returned to work and briefly returned to his duties as [redacted] before Christmas.

[redacted] was copied on emails between the executive officer, (Civilian Witness 3), and [redacted] regarding the media release on October 19, 2015, but he was not involved in the exchange.

In terms of media releases, Civilian Witness 3 and [redacted] were allowed by policy to release information to the media and did not need [redacted] approval to do so. Because of major case guidelines in the province, even though the matter was not considered a homicide, but it was a sudden death, the police service encouraged the Detective or the Detective Sergeant to meet with Civilian Witness 3 to ensure that the information was correct and accurate when they put out the media releases.

In relation to the first media release, [redacted] would have seen it sometime during the day. He was involved in the Inquest into the Deaths of Seven First Nations Youth (preparing the brief and the disclosure) so he was aware that language was an issue. He was not notified of the second media release. He subsequently found it in the email archive pertaining to general emails. [redacted] name was not on it anywhere, he did not recall being involved in it and did not know with whom Civilian Witness 3 liaised.

The amount of information that would be communicated to [redacted] as the [redacted] would be dependent on each individual investigation and what the Detective or Detective Sergeant thought he needed to know or if there was a concern. With major cases that involved homicide, that would obviously change and he would be informed and have regular meetings.

[redacted] stated that if [redacted] had wanted guidance around the investigation, he could have consulted him. [redacted] did not do so on this case. According to [redacted], they had a really experienced CIB with [redacted] as the Detective Sergeant. They also had a lot of experience with potential homicide cases and the need for [redacted] direction had lessened through the years. The Detective Sergeant would be the person who assigned officers to particular sudden death investigations.

[redacted] believed that the first media release was correct based on the investigation to that point. Although it was prior to the autopsy, but it was based on what the investigators believed and the facts they had at the time.

[redacted] did not wish to comment on whether it was a valid criticism that the second press release deeming the death *"non-criminal"* would have given the impression of a pre-judgement of the investigation as he was not involved in that press release.

[redacted] did not know about the information that [redacted] received on the scene from a witness. [redacted] said he would have expected that the information was recorded and reported and that [redacted] would have passed the information onto the CIB officers at the scene. The witness should have then been interviewed with a recorded statement. The individuals who were potentially in the company of the deceased the night before should also have been located and interviewed at headquarters.

Even if there were no signs of foul play at the scene, [redacted] would still expect that potential witnesses, who might have been with the deceased the night before, would be interviewed and recorded to see if they had any involvement in the death, or could direct the investigation.

The information that there had been a physical altercation between two men would have helped direct their investigation as well as have had a bearing on whether there could have been a criminal element to the death.

[redacted] was following the Inquest into the Deaths of Seven First Nations Youths at the time and watched some of his colleagues testify. It was a big topic of conversation in the office on a regular basis. He had been involved in some of the investigations. He could not remember specifically whether the Inquest was referenced during SD's investigation in relation to how the sudden death of an Indigenous person should be dealt with.

[redacted] could not specifically remember passing on any guidance regarding sudden death investigations of Indigenous individuals to his investigators prior to the investigation. He was willing to pass on his experiences working on sudden death investigations and had done so in the past. The people he managed worked with him, and not so much for him.

[redacted] mentored and passed along his experiences to the officers under his command. He remembered the first death investigations along the waterways and he believed that they had improved their case management function and learned from those investigations.

The TBPS CIB investigators were all university educated. [redacted] could not comment on what he may have told investigators regarding the investigation and whether different processes could have been used. He was not involved when the death was classified as *"non-criminal."*

[redacted] indicated that the investigation was a Coroner's investigation. The investigators would have liaised with the Coroner concerning the investigation. [redacted] could not comment on how it was deemed or labelled. If it was considered criminal, it would no longer be a Coroner's investigation and the police would launch a criminal investigation. [redacted] did not like the term *"labels,"* but the police do use terminology such as Coroner's investigation, criminal investigation, active/inactive and criminal or non-criminal. Terms would depend on who they were speaking to and who was case managing the file.

[redacted] reported directly to the Deputy Chief, who at that time was [redacted]. There were regular weekly meetings. [redacted] would also discuss with [redacted] the status of ongoing investigations. [redacted] would also get his own updates directly from investigators. There was the expectation that [redacted] would be updating [redacted] on a sudden death investigation, but each investigation was different. [redacted] did not recall specifically updating [redacted] about this investigation except for the first email. He said that he most likely did update him, but did not have any specifics offhand.

Other Evidence

Review of the Thunder Bay Police Service Investigation Concerning the Death of Stacy DEBUNGEE

On January 12, 2017, [redacted] of TBPS forwarded a letter to the Commissioner of the Ontario Provincial Police (OPP), J.V.N. Hawkes requesting that a review of the investigation into the death of SD be conducted. This was in response to a complaint received by the OIPRD regarding the investigation.

The review of the police investigation by the OPP began on February 1, 2017, and was conducted by Detective Inspector Shawn Glassford, Detective Staff Sergeant Matthew Watson and Detective Staff Sergeant Bradley Robson. They are all Major Case Managers assigned to the CIB.

The OPP reviewed:

- Police reports
- Officer notes
- Media releases
- Forensic investigation reports and photographs
- Autopsy examination report
- Witness statements
- Judicial authorizations
- Financial records
- OIPRD complaint and ISN report
- Policies (SOP) of the Thunder Bay Police Service
- Criminal Investigation Management Plan Part VI

They also attended the scene and reviewed the Fifth Estate documentary. The OPP review separated out the steps taken during the investigation and summarized and analyzed the steps taken and made recommendations for either follow-up that was required or future considerations in other investigations.

The OPP examined:

- Initial Response
- Scene Examination
- Media Response
- Next of Kin Notification and Liaison
- Autopsy Examination
- Exhibits
- Witness Interviews
- Judicial Authorizations (Financial Records)

Initial Response

The OPP found that the responding officers conducted their duties efficiently and in accordance with TBPS policy when first called to the scene. The body was determined to be deceased and officers secured the scene and the CIB was called.

The OPP did find that follow-up was required in obtaining formal audio/visual statements from witnesses who were on the scene including PP, KK and NN. A broader canvas of the local businesses and area residences should have been conducted in order to identify further potential witnesses.

For future investigations, the OPP recommended that all witnesses be interviewed at the earliest opportunity and that consideration be given to audio or video recorded statements in death investigations where foul play cannot be ruled out.

Scene Examination

[redacted] and [redacted] from the TBPS Forensic Identification Unit, attended the scene and marked and identified 10 exhibits. Photographs were taken of the scene and from where the exhibits were seized. The Coroner arrived and with the assistance of [redacted] and [redacted], the body was removed from the water. They located a plastic Ziploc bag in the water near the head of the deceased which included several items including a health card in the name of "Stacey Lance DeBungee," bearing his date of birth.

When removing the body, care should have been taken not to transfer evidentiary material between the scene and the body. The body was placed into a body bag, sealed with a numbered plastic seal and transported to the Thunder Bay Regional Health Sciences Centre. The scene was released at 11:45 a.m.

The OPP found that the photographs taken did not focus on the body and the riverbank area. That fact, and the fact that no video was taken, made it difficult to determine the positioning of the body, any indication of the point of entry and its overall state prior to its removal. In terms of the exhibits, based on the photographs there were other items that may have had evidentiary value. The OPP was not sure why certain items were seized as exhibits and others were not. Also, there were no measurements taken at the scene.

The scene was released at 11:45 a.m., on October 19, 2015. [redacted] wrote in his notes at 10:45 a.m., that he believed the death was non-suspicious in nature. There did not appear to be any basis for this conclusion at that stage especially in light of the cause of death not having been identified yet and a witness at the scene who indicated that he had seen two people in an altercation the night before.

The OPP recommended for follow-up that thorough measurements of the scene be obtained. Also, for future death investigations in which foul play cannot be ruled out, consideration should be given to holding the scene until the autopsy has been conducted. Also, when removing the body, it should be placed onto a clean surface like a tarp. In death investigations in which foul play cannot be ruled out, all exhibits with evidentiary value should be collected.

Media Response

Two media releases were issued: on October 19, 2015 at 12:45 p.m., and a second one on October 20, 2015 at 10:15 a.m. The first one *stated "An initial investigation does not indicate a suspicious death."* The second release identified the deceased and stated that *"Mr. DeBungee's death has been deemed non-criminal."*

The OPP found that it was too early to draw that conclusion. The investigation was ongoing and the autopsy had not been conducted. There was no basis to determine the death was non-criminal. TBPS policy stated that a potential homicide should be treated as a serious criminal matter and that lead investigators should be contacted by the media releasing officer before any media release.

The OPP recommended that for follow up, consideration should be given to issuing another media release indicating that the investigation remained active and further investigative steps were being undertaken. Also, for future consideration, consultation should take place between media relations personnel and the lead investigator and during any TBPS Criminal Investigation Branch-led investigation, the officer in charge should be consulted prior to circulation of any media release.

Next-of-Kin Notification and Liaison

On October 19, 2015, [redacted] and [redacted] attended the residence of SDSD's common-law spouse, Civilian Witness 4, and informed her of his death. Present were also CC, EE, AA and an unidentified male. There was no further follow up with Civilian Witness 4 after this date.

Complainant 1, the deceased's brother, attended TBPS headquarters on October 21, 2015, and spoke with [redacted] and was advised that the death was non-suspicious. At 6:55 p.m., on that same day, [redacted] called Complainant 1 to update him on the results of the autopsy examination.

In November 2015, a private investigator, Civilian Witness 4, retained on behalf of the Complainants tried to meet with the TBPS investigators, but did not receive a response. On November 24, 2015, Complainant 1 attended TBPS and spoke with [redacted] asking for investigative materials and expressing his dissatisfaction with the investigation.

While conducting the next of kin notification, the officers learned that people there had been in SD's company the night before. No formal statements were taken. They likely would have learned that EE had SD's bank card. Because of the premature determination of death, the investigating officers appear to have affected the process of obtaining needed investigative information from the next of kin and those individuals who SD was with the night of his death. Also, while investigators were not obligated to meet with the private investigator, if they had done so they would have obtained information from the private investigator regarding SD's financial records. TBPS knew, as of November 2015, that the DeBungee family was dissatisfied with the investigation, but no further steps were taken until March 2016.

The OPP recommended that as a follow up that TBPS should assign a liaison officer to establish and develop a positive relationship with the DeBungee family and update them on the investigation. For future consideration, officers doing next of kin notifications should be aware of the opportunity to obtain information related to the deceased's final movements, history, known associates, etc. and be equipped with portable audio recording devices to facilitate interviews.

Autopsy Examination

The autopsy examination was conducted on October 21, 2015, at the Thunder Bay Regional Health Sciences Centre. It was attended by [redacted] and [redacted]. No fresh signs of trauma were observed. The pathologist indicated the likely cause of death was drowning, but would provide a final opinion after the toxicology results. On January 29, 2016, the toxicology report indicated the cause of death was fresh water drowning with alcohol intoxication as a contributing factor.

The OPP did not identify any deviations of police activities from accepted police practice. No recommendations for follow up or future considerations were made. Complainant 1 in his complaint had commented that SDSD's nose was disfigured and may have indicated a fresh fracture. This was not borne out by the autopsy examination and SD's face looked similar to previous arrest photographs.

Exhibits

[redacted] retrieved the exhibits on October 26, 2015. Items that belonged to SD were returned to his family and FF's health card and a crumpled piece of paper that was FF's (no indication what was on this paper and how it was linked to FF) were returned to FF. Because of the determination this was a non-suspicious death no forensic examination was conducted on the exhibits.

Due to the belief that the determination that the death was non-suspicious was premature, the exhibits should have been retained until after the autopsy report. In future death investigations, exhibits seized should be maintained until the final autopsy examination report has been reviewed. No follow up was recommended unless exhibits remained and if so, consideration should be given to further forensic examination if warranted by future investigative direction.

Witness Interviews

From October 19, 2015, to February 2017, the TBPS conducted 16 interviews with civilian witnesses. The OPP reviewed and summarized the witness statements of: Civilian Witness 4, Civilian Witness 5, AA, CC, DD, EE, FF, GG, KK, MM, PP, QQ, RR, SS, TT and UU.

There were several witnesses at the scene on the morning of October 19, 2015, from whom formal statements were not taken. QQ was the only one who was formally interviewed and that interview occurred 16 months later. KK was a particularly important witness because of what he had observed the night before with an altercation between two men.

The information provided by GG regarding the admission made by HH that she was involved in SD's death was of interest. The OPP found it problematic that this initial information was provided to the TBPS on May 12, 2016, but not followed up until June 30, 2016. The information was initially misplaced within the HH sudden death report and may not have been known by investigators into the death of SD. HH was at the scene on the morning of October 19, 2015, but identified herself as OO.

Witness statements regarding SD's bank card and its use needed to be clarified. For example, based on the financial records (discussed below) SD's bank card was used to pay for a taxi. EE stated she took a taxi the night of SD's death with money from her mother. She said she did not know SD's PIN number and would not have stolen from him.

Also, FF made two statements that contained a discrepancy, the first one indicated that he did not know SD and had not seen him at the scene and the second one stated that he had been with SD at the scene.

CC told investigators that Thunder Bay police had approached their group on October 18, 2015, when they were asleep on the riverbank to ask them to move along. There was a police incident noted on that night where TBPS officers had attended SilverCity Movie Theatre and asked CC to move along. He had been drinking, but was not intoxicated. It was not clear if CC was referring to this event.

The OPP recommended the following steps as follow up for the investigation:

- A formal audio/visual statement should be obtained from KK
- A formal audio/visual statement should be obtained from PP
- A formal audio/visual statement should be obtained from NN
- A formal cautioned audio/visual statement should be obtained from EE to determine further details in relation to her utilization of SD's bank card
- A formal audio/visual statement should be obtained from FF addressing the discrepancies provided by him in his two statements to investigators
- A formal audio/visual statement should be obtained from JJ. Investigators should attempt to determine what time on the evening of the October 18, 2015 that FF arrived at the residence of JJ. Further, inquiries should be made with JJ concerning the demeanor and appearance of FF that evening
- A full background investigation should be conducted into HH. Further potential witnesses should be identified and interviewed regarding HH and any communication she may have had concerning SD
- A canvass of TBPS officers should be conducted to determine the veracity of CC's statement that he and the other members of his group were asked to move from their location on the riverbank by TBPS officers on the evening of October 18, 2015.

- A formal audio/visual statement should be taken from VV, sister of GG, concerning the meeting of GG and HH at the hospital and any discussion surrounding the death of SD
- Locate and interview WW concerning any conversations she may have had with CC regarding the death of SD

The OPP recommended for future investigations that *"In any death investigation all relevant witnesses need to be identified and interviewed at the earliest opportunity, with a coordinated plan and strategy in place. The passage of time and other variables can affect the recall of a witness. When practicable, audio or audio/visual equipment should be utilized."*

Judicial Authorization (Financial Records)

A production order was obtained and executed on November 22, 2016, for SD's banking records. The Information to Obtain the production order was subject to a sealing order and was not addressed by the OPP. Bank records were obtained for SD's bank account and the focus for the investigators was the time period from October 18 to 20, 2015. There were no transactions on October 18, 2015. There were four money transfers into the account totaling $169. There were cash withdrawals (two for a total of $105) and three point of sale purchases (Roach's Taxi, Canadian Tire and LCBO). Some of these were explained and cross-referenced with witness statements. There were identified discrepancies, but that could have been due to posting practices of the financial institution.

The OPP recommended as follow up the following:

- Further investigation with the bank to obtain the actual times and dates of all transactions pertaining to the account of SD.
- Consider a further review of the activity of SD's bank account. A period of time well before October 1, 2015 should be considered to show any patterns of use consistent with other persons utilizing the account for deposits and transactions.
- An interview of the mother of EE should be conducted to ascertain details surrounding her depositing of funds into the account of SD.
- Contact Roach's Taxi Company and determine details of trip identified in point of sale purchase. Since a banking card was utilized records should exist.
- Contact LCBO and Canadian Tire and obtain point of sale purchase details.
- Determine coding details utilized within the account transaction summary of SD (i.e. PGT credit).

There were no recommendations made for future consideration in other investigations.

Conclusion

After SD's body was found on October 19, 2015, the autopsy examination was conducted on October 21, 2015 and report issued on January 29, 2016, advising death was due to drowning with alcohol intoxication as a contributing factor. No further investigatory steps were taken until March 28, 2016, when investigators spoke with FF. Further investigation occurred through 2016 and 2017, but was of limited value because of the amount of time that had passed since the death.

The OPP concluded that there was no direct evidence that SD met his death as a result of a criminal act, but there were several factors in the investigation that were of concern.

The concerning areas that required follow up include HH and any involvement that she may have had in SD's death. HH was at the scene the morning SD's body was found and had told police that she did not know the deceased, or had any interactions with him. She also used another name. GG alleged that HH admitted that she was responsible for SD's death. There was no evidence that corroborated that and HH died in the spring of 2016. Further investigative steps needed to be taken to determine the veracity of GG's allegation.

KK witnessed an altercation between two men the evening before SD's body was found which raised the possibility that SD's death was a result of that activity. A formal interview of KK needed to be conducted.

SD's bank card was used after his death raising the possibility that persons associated with him had it before his death or obtained it after his death. It was common for SD to allow others to use his account to access funds. Further investigation needed to be conducted to eliminate the bank card as a motive for any criminal activity.

While significant time has passed, the OPP reviewers believed that following their recommendations for follow up steps, the investigation could still be completed successfully bringing the case to a satisfactory conclusion and determine the truth around SD's death.

Investigation

1. Interviewed two Complainants.
2. Interviewed seven Civilian Witnesses.
3. Interviewed 13 Witness Officers.
4. Interviewed 11 Respondent Officers.
5. Obtained and reviewed the following evidentiary documents from the Thunder Bay Police Service (TBPS) including, but not limited to:
    - Officer notebook entries
    - Occurrence Reports
    - SD Investigative File
    - Coroner's Report
    - Toxicology Report
    - 911 Recording
6. Reviewed ISN (SD) Sudden Death Investigation.
7. Reviewed OPP investigation into death of SD.
8. Reviewed applicable statutes, regulation *including:*
    - Ontario Regulation 268/10
    - Schedule Code of Conduct
    - *Ontario Human Rights Code*

Analysis

Neglect of Duty

On the morning of October 19, 2015, a passerby saw a body in the McIntyre River. A 911 call resulted in paramedics, Thunder Bay Police Service uniformed officers, members of the Criminal Investigation Branch, the Coroner and TBPS's executive officer attending the scene. The body was removed from the river and he was pronounced dead. Officers at the scene tentatively identified the deceased as SD. That identification was subsequently confirmed.

On October 21, 2015, the autopsy was conducted. Very little was done to investigate the death between October 21, 2015, and January 29, 2016, when the autopsy report formally attributed SD's death to drowning with alcohol intoxication as a contributing factor.

On March 18, 2016, the Complainants filed a complaint with the OIPRD. The complaint challenged the adequacy of the investigation and referred, among other things, to deficiencies in the TBPS investigation identified by Civilian Witness 7, a private investigator retained by the Complainants.

On March 28, 2016, the police took further investigative steps when they interviewed the person believed to be last seen with the deceased, referred to as FF.

The complaint to the OIPRD and concerns on the part of TBPS's senior management, particularly [redacted], about how the TBPS's investigation had been conducted, prompted the reassignment of the file to [redacted] and [redacted]. [redacted] The OIPRD's Investigative Report focuses on the TBPS investigation into SD's death prior to the reassignment of the file.

On January 12, 2017, [redacted] asked the OPP to review the investigative file. The OPP's report has been summarized earlier in this Investigative Report.

The OIPRD named 13 Respondent Officers. That large number of Respondent Officers reflected the absence of detailed information from the Complainants as to the specific officers involved in the investigation. It was also fair to provide procedural protections to any potentially affected officers until their involvement was known.

The evidence established that [redacted] was the officer primarily in charge of the investigation. He was also described as the lead investigator, although one officer suggested that the term *"lead investigator"* was reserved for matters subject to Major Case Management. The evidence bearing on [redacted] lead role in the investigation included the following:

(a) [redacted] said that [redacted] was the Sergeant in the case and would direct the other officers. He said that [redacted] was not the *"lead investigator"* as the case did not fall under the major case model. Suspicious deaths, rather than sudden deaths, would fall under that model. He also said that it was not his ([redacted] role to review the contents of the file and determine if the investigation should be *"ramped up."* He believed that was the decision of [redacted] and his supervisor.

(b) [redacted] referred to [redacted] and [redacted] as the original investigators on the file.

(c) [redacted] said that at the scene, there was no discussion as to who the lead investigator would be. [redacted] was the boss and would usually point out who would be the lead. He indicated that they did not really have a system.

(d) The executive officer, Civilian Witness 3, obtained approval from [redacted] for the contents of the first media release pertaining to SD's death. That was supported by the existing email chain concerning the first release. Based on the role he performed, it is also likely that [redacted] approved the second media release as well, although the evidence was less clear on that point. [redacted] could not confirm that he approved the second release. Civilian Witness 3 said that he would have spoken to [redacted], or [redacted] before the release was issued. [redacted] was undoubtedly aware of the contents of the second media release and there was no suggestion that he disapproved of the contents. If [redacted] approved that release, it is unlikely that they did so unless [redacted] also approved it or its contents conformed to what he had told them.

(e) [redacted] took the lead, (though [redacted] were present as well), in speaking with Complainant 1, Civilian Witness 6 and their aunt when they attended the police station on October 20, 2015, to learn more about the investigation. He also made the decision whether the police would meet with the private investigator, Civilian Witness 7, retained by the Complainants.

In describing [redacted] as the lead investigator or officer-in-charge, there appeared to be little or no formal process for how a lead investigator was assigned and very little supervision or oversight of the investigation thereafter. That reflected, among other things, a misconception of the nature of the sudden death investigation and organizational deficiencies.

This sudden death should have been treated as a potential homicide – and investigated as such. There was no basis to affirmatively rule out foul play based on observations made at the scene or even after the autopsy examination. It could be speculated that the death resulted from an accident (such as falling into the river while intoxicated) or criminal activity (such as the deceased being pushed into the river) or be explained by a number of other scenarios. However, such speculation was no substitute for an evidence-based and informed investigation.

As several officers acknowledged, the absence of obvious trauma or injuries attributable to a physical altercation does not determine whether the death resulted from an altercation. Similarly, the determination that the deceased drowned, and that intoxication was a contributing factor in his death, is compatible both with accident and with criminal activity resulting in the deceased being pushed into the river.

The Coroner, Civilian Witness 2, acknowledged that they did not know if the deceased was pushed into the river or fell in, which would be hard to tell without an eyewitness and only based on an autopsy. The autopsy revealed minor scratches and cuts on the deceased according to [redacted] one of the Forensic Identification officers, which again would be consistent with either accident or criminal intervention.

Several officers, including [redacted], showed a deeply troubling misconception about what a criminal investigation entails. Several officers asserted that there was no evidence of foul play or suspicious circumstances. They believed that, as a result, it remained essentially a Coroner's case or a non-criminal matter unless such evidence was discovered, in which event the police would initiate a thorough criminal investigation.

As the OPP observed in its detailed review, in the absence of an ability to affirmatively rule out foul play, a sudden death must be dealt with as a potential homicide and investigated as such. Otherwise, we would add, the police are unlikely to take appropriate steps to determine, as best they can, whether there is evidence of criminality. If no thorough investigation takes place unless the police already have affirmative evidence of criminality, less obvious cases of homicide will remain undetected. So the fact that [redacted] cited a high rate of success in solving homicide cases does not truly speak to the adequacy of sudden death investigations.

The evidence is clear that an evidence-based proper investigation never took place into SD's sudden death while [redacted] led what little investigation took place. [redacted] concerns about the adequacy of the investigation up to that point were justified – indeed, he was unaware at that time of the depth of the inadequacy revealed through the OIPRD investigation. Later, the OPP's independent review of TBPS's investigation, which did not have the benefit of the interviews the OIPRD conducted, nonetheless identified a number of deficiencies in the TBPS's investigation – some of which are also noted in the OIPRD's Investigative Report. In this regard, we also observe that the OPP reviewed the TBPS's investigation after the file had been reassigned, not merely up to the point of reassignment. To state the obvious, those involved in the original investigation, most particularly [redacted], played no role in the further investigative work that subsequently took place.

The deficiencies in the investigation led by [redacted] included the following:

1. **The CIB investigators prematurely determined that the death was non-criminal. The available evidence did not support the conclusion that foul play had been excluded. This infected the entire approach to the minimal investigation which followed.**

Civilian Witness 7, the private investigator retained by the Complainants, observed that even if an investigator believed that the deceased was intoxicated and somehow rolled into the river after falling asleep and simply drowned, it remained a death investigation, which had to be done to the highest standards. Had he investigated the incident, he would not have written if off as simply being a drowning. There were just too many unanswered questions. There were several people who needed to be interviewed and possibly polygraphed. Based on his own experience, he believed that this should have been classified as a suspicious death. It would have been better to approach the investigation from that perspective. An investigator should not make assumptions unless confident that supporting evidence is available.

[redacted], who took over the file at the direction of senior management, believed that there were many unanswered questions as to whether SD's death was accidental or criminal. The subsequent work done by [redacted] and [redacted], as well as the OPP review, highlighted the deficiencies in the earlier investigation.

[redacted] expressed concern that the original investigators, [redacted] and [redacted] had prematurely concluded that the death was accidental without having conclusive autopsy results and without completing witness statements. He also had concerns about the financial transactions involving use of the deceased's debit card after his death. Due to his dissatisfaction with the progress of the original investigation, he had the original detectives replaced by [redacted] and [redacted] He did not feel, however, that the failings in the original investigation were attributable to racial bias.

[redacted] wrote in his notes at 10:45 a.m., on October 19, 2015, that he believed the death was non-suspicious in nature. The OPP concluded that there did not appear to be any basis for this conclusion at that stage, especially in light of the cause of death not having been identified yet and a witness at the scene indicating that he had seen two people in an altercation the night before. (We address [redacted] connection to the latter point below.)

In the interviews conducted with OIPRD investigators, the TBPS investigators demonstrated how poorly they understood their responsibilities in this sudden death investigation.

[redacted] said that he had seen a lot of dead bodies and the ones that met with foul play showed signs of foul play, unlike the deceased. According to him, after the Coroner's cursory examination, the Coroner indicated that there did not appear to be any trauma to the body. He said that, at that point, it became a Coroner's case and he did not have the same supervision that he would have as a Major Case Manager had the death been deemed to be a homicide. He explained that based on the Coroner's determination that there were no obvious signs of trauma and there did not appear to be any foul play or suspicious circumstances, he would assist the Coroner if the Coroner required something to be done.

The absence of obvious trauma at the scene, and even after the autopsy, did not entitle the investigators to dismiss it as a potential homicide case or treat it as a Coroner's case. As a number of witnesses acknowledged, the absence of obvious signs of trauma was not inconsistent with criminal intervention, such as the deceased being pushed into the river. The real issue should have been whether anything pointed to foul play or suspicious circumstances **after** a proper investigation, not before.

[redacted] said that there was no forensic evidence from the scene that pointed to a particular theory of how the deceased ended up in the river. He observed that there was nothing that pointed to it being a suspicious death. He said that they did not know one way or the other whether it was a criminal event.

The fact that they did not know one way or the other whether it was a criminal event supported the importance of doing a thorough criminal investigation – not the contrary.

On October 21, 2015, the CIB investigators met with Complainant 1 and other family members. There are differing accounts of what was said at that meeting. [redacted] said that [redacted] told the family that there was nothing to indicate that foul play was involved in the death of SD. If new information pointed to criminal activity, they would launch an investigation or look into it further. According to [redacted] only said that rolling into the river was one of the possibilities. He said, *"He may have rolled in. We don't know. We may never know how he ended up there."*

If the police felt that rolling into the river was only one of the possibilities at play, this supported the need for a thorough investigation – not a cursory examination of the death unless new information justified the launching of an investigation. Unfortunately, whatever was said to Complainant 1, the police proceeded as if further investigation was largely unnecessary, and it could be presumed that the deceased rolled into the river on his own.

2. **No formal statements were taken from any of the individuals who were with the deceased shortly before his death. The police briefly spoke to some of these individuals in a group setting. The conversation which ensued is best described as superficial. These individuals should have been formally interviewed at the earliest opportunity. These interviews should have been properly recorded and conducted with each individual, rather than in a group setting.**

Such formal statements would likely have yielded evidence relevant to the investigation: for example, evidence pertaining to the use of the deceased's debit card post-death. This was an important avenue for further investigation, whether it was ultimately proven to be relevant to the cause of death. As the OPP accurately concluded, the premature determination of the cause of death appeared to have affected the process of obtaining needed information from the next of kin and those individuals who were with the deceased the night before he was found.

[redacted] said that [redacted] and [redacted] made no attempts to interview anyone who was at the residence of the deceased's common-law spouse since they advised officers that they had left the deceased there with FF. Based on that information, the police determined that they were not the last people to see him.

[redacted] said there was no thought of bringing in the people who had been with the deceased for formal interviews. This was a sudden death, there was no indication that it was suspicious and it was not a major case. There was nothing indicating that it was criminal. It they had anything pointing to it being criminal, they would launch into a criminal investigation. [redacted] said that if the CIB officers had been aware that criminal activity was involved, they would have interviewed the individuals who had been drinking with the deceased.

It is remarkable that the CIB officers would choose not to formally interview any of these individuals because they asserted, in a group setting, that they had left the deceased with FF or because the police first had to become aware that criminal activity was involved **before** such interviews would be conducted.

[redacted], [redacted] immediate supervisor, who was generally supportive of the work done by the CIB investigators under her supervision, indicated that it was essential for the investigation to speak to people who were with the deceased the night before he was found, including FF. An autopsy would not reveal, for example, if the deceased had been pushed into the river. She expected that the investigators would take formal statements from people to find out whether there had been any altercation between FF and the deceased.

[redacted], to whom [redacted] reported, observed that even if there were no signs of foul play at the scene, he would still expect that potential witnesses who might have been with the deceased the night before would be interviewed and recorded to see if they had any involvement in the death or could direct the investigation.

It was significant that Civilian Witness 7 was able to piece together, after brief investigative efforts on his part, what the deceased did the day prior to his death. He was also able to identify the individuals who had been with him prior to his death, none of whom had been interviewed by the police. He obtained some information about the financial activity associated with the deceased, which was relevant to a proper investigation.

3. **Two media releases were issued. The first was issued on October 19, 2015, at 12:45 p.m., stating that "an initial investigation does not indicate a suspicious death." The second was issued on October 20, 2015, at 10:15 a.m., stating that "Mr. DeBungee's death has been deemed non-criminal." These media releases presupposed, even before the autopsy had been performed, that the death was non-criminal.**

In the discussion concerning [redacted] role as lead investigator, his involvement in approving or accepting the contents of the media releases has been addressed.

As indicated earlier, the OPP concluded that there was no basis, at that stage, to determine that the death was non-criminal. A potential homicide should be treated as a serious criminal matter. The media releases undermined confidence in any criminal investigation which followed, which should have been foreseeable by [redacted] in light of the existing issues between TBPS and Indigenous people. The media releases also potentially undermined the willingness of witnesses to come forward.

The private investigator regarded the media releases as one of the first flags that were raised for him about the investigation:

> *"That they were so quick to go to the media and say that no foul play was suspected and that there was no criminality. As an Investigator, and especially somebody that's experienced in death investigations, that just seemed like that was happening long before, you know, the police had time to interview people, speak to the family, speak to any potential witnesses, the last people who saw him and so on. And certainly to see what the Coroner had to say."*

In fairness, Civilian Witness 7 acknowledged that sometimes the police would make an announcement for public safety and to ease the community's fears. However, in his opinion, in light of all the circumstances surrounding the case, including the ongoing Coroner's Inquest, it was premature to announce that there was no criminality on the same day the body was recovered. In his view, this was certainly not in keeping with standard protocols of death investigations.

4. **The CIB investigators, most importantly, [redacted] did not review, on an ongoing basis, supplementary occurrence reports in the investigative file, and as a result, was unaware, for example, of the informal interview with KK conducted at the scene by an uniformed officer in which a witness described a physical altercation between Indigenous men at the scene the night before the deceased's body was found. Formal interviews should have been conducted of KK and others informally interviewed by uniformed officers at the scene.**

[redacted] took an important statement from KK at the scene. KK described a group of apparently intoxicated Indigenous men and a woman in close proximity to where the deceased's body was found the evening before the deceased's body was discovered. He also described a physical altercation between two of the men.

Despite the obvious importance of the statement, [redacted] was uncertain whether he passed this information about KK on to the CIB at the scene, though there was no reason why he would not have done so. [redacted] was 100 per cent confident that [redacted] would have spoken to the CIB at the scene about his interview with the witness. However, he had no first-hand knowledge to support that view. [redacted] would also have expected the uniformed officer to advise the CIB at the scene, but again, had no first-hand knowledge as to whether that expectation was fulfilled. [redacted] said that the information was not passed on at the scene. [redacted] was unaware of this information. [redacted] would have expected a uniformed officer to convey this information to the CIB at the scene. He does not recall if he was aware of the report at the time.

Based on the available evidence, it cannot be confirmed that [redacted] conveyed this information to the CIB investigators at the scene. However, he filed a Supplementary Occurrence Report detailing this information on October 19, 2015, at 13:28. It was in the investigative file.

It was essential to a proper investigation into the circumstances surrounding this death that the investigators actually read the information pertaining to the investigation on an ongoing basis. That was basic policing. [redacted] expected that the investigating officer would have read the Supplementary Occurrence Report filed by [redacted] and followed up on it. However, the evidence supported the conclusion that none of the CIB investigators did so.

[redacted] told the OIPRD investigators that he had no cause to do so. He said he was never directed to read the report and the investigation was never ramped up as a criminal case so he was not reviewing everything. He had other cases he was working on and it was not his job to review everything to make sure *"it isn't something more than what we have."* Ramping up the investigation would be a decision for his superiors. [redacted] and the Staff Sergeant would be reviewing things.

His explanation reinforced the conclusion that the CIB investigators misconceived the nature of the investigation which was required. The principal officers tasked with conducting the investigation were obligated to familiarize themselves with the available evidence in the investigative file and take appropriate steps to follow up on it. As a result of this failure, KK was not interviewed again until well after the relevant events – and only after the file was reassigned.

As already indicated, [redacted] would have expected that the information received by the uniformed officer from KK would have been recorded and reported and that the officer would have passed that information on to the CIB at the scene. [redacted] said that a recorded statement should have been obtained from the witness.. The information that there had been a physical altercation between two men would have helped direct their investigation as well as having a bearing on whether there could have been a criminal element to the death.

It should also be noted that [redacted] filed a supplementary report pertaining to his encounter with CC, one of the individuals who was with the deceased the night before he was found. The encounter with [redacted] took place that same night. According to [redacted] requested that he file a supplementary report pertaining to the encounter. [redacted] denied that he requested that a uniformed officer provide a supplementary report pertaining to the incident involving CC. In any event, there appeared to have been no follow-up in relation to the information. [redacted] said that he had no further involvement in the investigation after the meeting with the family on October 21, 2015.

In addition to the supplementary occurrence reports, uniformed officers spoke to additional individuals at the scene. [redacted] spoke to NN, OO and QQ at the scene, although he did not personally feel they had relevant information. However, according to him, OO and QQ purportedly found the health card in FF's name. The OPP report reflected that OO was, in reality, HH. There was also some evidence, later developed, that QQ indicated to family members that he had discovered the body. Formal follow-up statements of the witnesses identified at the scene may well have yielded additional information, including any connection between HH and the deceased.

As reflected in this report, HH allegedly confessed to pushing the deceased into the river, although this information came to the attention of the police well after the relevant events. The OPP report made recommendations as to follow-up interviews which should still take place in relation to some of these individuals. The OPP reflected that QQ was the only one who was formally interviewed, but that interview occurred 16 months later. The OPP regarded KK as a particularly important witness because of what he had observed the night before respecting an altercation between two men.

5. **The CIB investigators provided inadequate or no direction to the Forensic Identification Unit in a manner consistent with treatment of the sudden death as a potential homicide. No video was taken of the scene; no photographs of the body itself or the riverbank in close proximity to the river were taken. No consideration was given to holding the scene until the autopsy had been conducted. No measurements were taken at the scene.**

The OPP noted that the photographs taken did not focus on the body and the riverbank area. It was observed that this fact, and the fact that no video was taken, made it difficult to determine the positioning of the body, any indication of a point of entry and its overall state prior to its removal from the water.

[redacted] a member of the Forensic Identification Unit, acknowledged that no videos were taken at the scene. She felt that the Unit would only take videos at scenes they believed were homicides. [redacted] said that they did not take a video since the death was not regarded as suspicious. He said that it was not believed to be anything more than a drowning. He is not sure who made that decision, but thought it was the Coroner. He later stated to OIPRD investigators that he thought the decision to treat the scene as not suspicious would have been a combination of everyone's input, including the Forensic Identification Unit, CIB and ultimately the Coroner. If it had been a suspicious scene, they would have used video and held the scene until after the autopsy.

The evidence of the Forensic Identification Unit officers reinforced the conclusion that, for all intents and purposes, the CIB investigators treated the death as a non-suspicious death virtually from the outset. The Coroner's input did not relieve the CIB investigators of their responsibility to conduct a proper criminal investigation.

6. The TBPS's efforts to contact FF, who, by some accounts, was the last person known to be alone with the deceased, were sporadic and were given the lowest priority. The interview ultimately conducted with FF took place a long time after the material events.

The efforts to find and interview FF were described earlier in this Investigative Report. Based on [redacted] advice, FF's name was red-flagged within the service's systems, but other police interactions with him may not have been brought to the attention of [redacted].

[redacted] told the OIPRD investigators that they never heard from FF after leaving a message with his father where he was supposed to be staying. They red-flagged him on the police system, and then did nothing about it whatsoever until the issue was raised with [redacted] by senior management in March, 2016. He said that no other attempts were made to contact FF. He said that despite the fact that there was a warrant for his arrest, the police were more concerned with criminal investigations and do not go looking for people with outstanding warrants. He stated*, "That's not my job. I've got other stuff to do."* He felt that the case remained a Coroner's investigation and he had numerous other incidents he was investigating.

[redacted] said that no further attempts were made to find FF. He said that if it had been a major case (that is, a homicide), the police would have followed up. But at the time, it was a sudden death case, rather than a criminal investigation. So there was no urgency in speaking with FF.

On March 24, 2016, [redacted] asked [redacted] about FF. He told [redacted] that FF had been on the BOLO. [redacted] described this as *"a problem,"* likely because he had become aware that the police had interacted with FF since his name had been red-flagged. It was obvious that [redacted] resented [redacted] intervention, feeling that [redacted] was *"poking"* him. He said that he did not need to be told to follow up with FF if FF was in custody.

The evidence provided to the OIPRD by [redacted] and [redacted] reinforced, yet again, the conclusion that they misconceived their responsibility to treat the matter as a potential homicide, rather than a Coroner's case. This explained their failure to take proactive steps to find FF. They only interviewed FF on March 28, 2016, over five months after the material events. The delayed interview, and the officers' perspective on the nature of their investigation likely affected both the quality of the interview and the evidence obtained as a result.

The entire approach to this witness also confirmed one key component of the Complainants' concerns: namely, that despite [redacted] protestation to the contrary, the investigation was not being taken sufficiently seriously. [redacted] reaction to [redacted] intervention was also somewhat troubling. The Chief was fully justified in raising the issue with him.

7. The matter was not dealt as an investigation subject to Major Case Management. It should have been. Even if it was not formally so designated, there was no investigative plan, no organized evaluation of ongoing steps to complete the investigation, all stemming from a mischaracterization of the nature of the investigation.

This deficiency has already been highlighted throughout the report. The investigators' characterization of this matter also meant that no investigative plan was developed to attempt to address the significant unanswered questions that arose.

8. No broader canvas of the local businesses and area residences was conducted, standard fare for a potential homicide. OPP noted this deficiency as well.

[redacted] indicated that he walked up and down looking for external cameras on buildings close to the scene. He did not see any and that was the extent of his efforts. In his experience, if he could not see an external camera, it meant that one did not exist. That approach could hardly be described as thorough.

9. [redacted] chose not to meet with Civilian Witness 7, the private investigator and former homicide detective. [redacted] said that he was not going to speak to any private investigator about the case.

As the OPP observed, although investigators were not obligated to meet with the private investigator, had they done so, they would have obtained information about, among other things, the deceased's financial records. It can reasonably be inferred that the tension between Complainant 1 and [redacted] explained, at least in part, why [redacted] chose not to even speak with the private investigator. It would have advanced the investigation – and potentially have improved the uneasy relationship with the deceased's family – to meet with the private investigator to learn what, if anything, he had discovered. There was no obligation, of course, on [redacted] to reciprocate by sharing confidential information with the investigator.

As Civilian Witness 7 observed, if a family believed that something untoward happened to their loved one, it is up to the police to take that seriously and investigate the matter. Unfortunately, [redacted] decision not to meet with the private investigator further contributed to the family's reasonably held belief that the matter was not being taken sufficiently seriously.

10. **The OPP found that [redacted] retrieved the exhibits on October 26, 2015. Items that belonged to the deceased were returned to his family, and FF's health card and a crumpled piece of paper said to belong to him was returned to him. Because of the premature determination that this was a non-suspicious death, no forensic examination was conducted on the exhibits.**

It is acknowledged that an investigator's incomplete or imperfect work will not necessarily rise to the level of misconduct or, to use the language contained in the Code of Conduct, a neglect of duty. For example, the OPP made suggestions as to how TBPS's investigation after reassignment might have been improved. It also suggested follow-up that might still be done. As stated earlier, the focus was on the investigation led by [redacted]

It is also acknowledged that not every deficiency identified in the investigation led by [redacted] was of equal importance. However, here, the deficiencies in the investigation were so substantial – and deviated so significantly from what was required as to provide reasonable and probable grounds to support an allegation of neglect of duty. I

It was also troubling that this inadequate investigation took place in the context of an ongoing coroner's Inquest into the Deaths of Seven First Nations Youths, most involving river-related deaths. As [redacted] acknowledged, one would have reasonably expected that investigators would be particularly vigilant in ensuring that the investigation of the sudden death of an Indigenous man found in the river was thorough and responsive to the community's concerns. Unfortunately, the opposite was true here.

First, in defence of the officers, it has been suggested that the police took their direction from the Coroner. It is a basic tenet of policing that the Coroner does not direct an investigation into a potential homicide. It must be the police who dictate what such an investigation entails. As Civilian Witness 7 stated, it is the responsibility of the police to conduct any investigation outside of the autopsy.

It has also been suggested that Civilian Witness 7 had better access to Indigenous witnesses in light of his retainer on behalf of the Complainants. However, this was not a situation in which TBPS investigators faced non-cooperation when they interviewed Indigenous witnesses. Instead, they failed to follow up with identified witnesses in an adequate or timely way. In any event, police must be proactive in building trust in relation to each investigation. Little or none of that occurred here. Civilian Witness 7's offer to share what he learned with investigators was spurned for no valid reason. [redacted] bears prime responsibility for the investigation he led.

Therefore, upon review and analysis of all available information, the Director has determined that there is sufficient evidence to establish that misconduct occurred in this complaint. As a result, with respect to the allegation of neglect of duty, the conclusion is: **Substantiated** against [redacted].

[redacted] played a significant role in this inadequate investigation. Although he bears less responsibility for it than [redacted], he too misconceived his responsibilities, and was involved throughout, right up to and including the interview he and [redacted] conducted with FF.

Therefore, upon review and analysis of all available information, the Director has determined that there is sufficient evidence to establish that misconduct occurred in this complaint. As a result, with respect to the allegation of neglect of duty, the conclusion is: **Substantiated** against [redacted].

Although [redacted] was one of the three CIB investigators who attended the scene, the home of Civilian Witness 4 and the meeting with Complainant 1 and other family members on October 21, 2015, the evidence of neglect of duty on his part was less compelling. Although he too misconceived the nature of the investigation required in the circumstances, his involvement in the file ended on or about October 21, 2015. The allegation of neglect of duty against [redacted] is **Unsubstantiated**.

[redacted] and [redacted] were named as Respondent Officers. There was no evidence to support misconduct on their part. The allegation of neglect of duty against both officers is **Unsubstantiated.**

[redacted] initially interviewed KK, and appropriately prepared a Supplementary Occurrence Report pertaining to the interview. It was completed in a timely way and placed in the investigative file. It remained unclear whether he advised the CIB investigators at the scene about the interview. If the CIB officers remained on scene, it would have been highly preferable – and expected – that he would have advised one of the CIB investigators of this information. Even if he did not, the error does not rise to the level of misconduct. The allegation of neglect of duty against [redacted] is **Unsubstantiated**.

[redacted] played a very limited role in the investigation and was not expected to oversee the investigation thereafter. There was no evidence supporting misconduct on his part. The allegation of neglect of duty against [redacted] is **Unsubstantiated**.

[redacted] and [redacted] attended the scene as members of the Forensic Identification Unit. While the OPP identified certain deficiencies in the forensic work done at the scene, they did not rise to the level of misconduct, particularly given their reasonable understanding of the determination (albeit flawed) that had already been made by the CIB investigators and perhaps the Coroner as to the circumstances surrounding the death. In all the circumstances, the allegation of neglect of duty against both officers is **Unsubstantiated**.

[redacted] was [redacted] immediate supervisor. As such, she was responsible for supervising the investigation into SD's death. At a minimum, such supervision required that she inform herself about the investigation, provide oversight and guidance where required, and ensure that the investigation was being conducted in a competent way.

There is compelling evidence that [redacted] supervision and oversight of the investigation led by [redacted] was wholly inadequate. She was either unaware of or indifferent as to the serious deficiencies in the investigation. Our earlier observations bear repeating. We stated that *there appeared to be little or no formal process for assigning a lead investigator in this matter, and very little supervision or oversight of the investigation thereafter. This reflected both a misconception of the nature of the investigation, which should have resulted from this sudden death, and organizational deficiencies.*

[redacted] told OIPRD investigators that she had certain expectations in connection with the investigation. These have been summarized above. However, she did not take adequate steps to ensure that even those modest expectations were met. Although not essential to the Director's decision, it is noteworthy that [redacted] continued to express confidence in the conclusion reached by the original SD investigators even though subsequent events, including an alleged confession by HH, raised important questions about the reliability of the original conclusion that foul play was not suspected.

[redacted] does not bear sole responsibility for the absence of adequate supervision and oversight of the SD investigation. At the time of the investigation, TBPS did not have a formal review process for ongoing death investigations. That raised obvious systemic issues. A culture of critical assessment by supervisors of ongoing death investigations did not appear to exist, certainly in relation to sudden death cases. Secondly, it appeared as though the supervisors placed undue reliance on the experience and purported expertise of senior investigators under their command. Whether that reliance was justified for recognized homicide cases, it was unjustified for this sudden death investigation.

Therefore, upon review and analysis of all available information, the Director has determined that there is sufficient evidence to establish that misconduct occurred in this complaint. As a result, with respect to the allegation of neglect of duty, the conclusion is: **Substantiated** against [redacted].

[redacted], in turn, reported to [redacted]. He retired during this conduct investigation. From the date of his retirement, the OIPRD lost jurisdiction over his conduct. Sadly, he passed away shortly after his retirement. In the circumstances, the Director makes no findings as to whether the allegation of neglect of duty would have been substantiated or unsubstantiated against him.

Discreditable Conduct

As earlier indicated, a police officer engages in discreditable conduct if he or she fails to treat or protect persons equally without discrimination with respect to police services because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability.

Investigators interviewed by the OIPRD, most particularly [redacted], forcefully asserted that deaths involving Indigenous people were treated no differently than those involving non-Indigenous people. He was insulted by allegations of bias. He said that, due to the social issues in Thunder Bay, the majority of death investigations, especially the homicides, have involved First Nations persons. He worked hard on those cases to try to get closure for the family.

On the available evidence pertaining to this investigation, we accept that [redacted] and others believed that they do not engage in differential treatment based on race. It is also accepted that [redacted] attendance at the scene to assist the deceased's family in identifying where the deceased was found, was well-intentioned, despite the family's suspicions around his attendance at the scene. However, the evidence overwhelming supports the inference that [redacted] and [redacted] prematurely concluded that SD rolled into the river and drowned without any external intervention. It can also be reasonably inferred that this premature conclusion may have been drawn because the deceased was Indigenous.

Civilian Witness 7, an experienced investigator, felt that the police had *"tunnel vision"* in relation to the investigation. At the Inquiry into Proceedings involving Guy Paul Morin, the Commissioner defined tunnel vision as *"…a single-minded and overly narrow focus on a particular investigative or prosecutorial theory, so as to unreasonably colour the evaluation of information received and one's conduct in response to that information."* In Civilian Witness 7's view, TBPS investigators acted as though they had another intoxicated Indigenous person who fell asleep at the river and that the only probability was that he rolled into the river and drowned. His view finds support in the evidence available to us.

At the scene, investigators did not know whether SD was intoxicated at the material time. Nonetheless, they showed little determination to truly keep an open mind as to what transpired. Even the evidence of SD's intoxication did not point only to an accidental drowning, nor did it exclude, without proper investigation, foul play contributing to how he ended up in the river. The police were not justified in adopting an approach which too readily assumed that intoxication explained a sudden death, or warranted a diminished level of diligence in investigating what happened.

A finding of discreditable conduct is not dependent on an intention to discriminate, or even subjective awareness, at the time, that the conduct involves a failure to treat or protect persons equally without discrimination based on race and other enumerated grounds. The actions of the officer do not have to be overtly racist in order for a finding of discrimination to be made. It can reasonably be inferred that the investigating officers failed to treat or protect the deceased and his family equally and without discrimination based on the deceased's Indigenous status.

In Ontario, it is public policy, as reflected in the Ontario Human Rights Code, to recognize the inherent dignity and worth of every person and to provide for equal rights without discrimination. Persons, in this context, include those whose deaths are being investigated, along with their families. It can reasonably be inferred that the investigation conducted by [redacted] and [redacted] failed to fulfill that public policy.

Therefore, upon review and analysis of all available information, the Director has determined that there is sufficient evidence to establish that misconduct occurred in this complaint. As a result, with respect to the allegation of discreditable conduct, the conclusion is: **Substantiated** against [redacted] and [redacted].

Post Script

We have mentioned several times that the focus of this Investigative Report was on the investigation that preceded the complaint. However, we would be remiss in failing to identify some serious concerns about the treatment by TBPS of information pertaining to HH's alleged confession.

On May 12, 2016, a TBPS assistant advised [redacted] that GG had contacted the police about a death. He followed up with GG who informed him about HH's confession to having a shoving match with the deceased in which the deceased ended up in the river. [redacted] was aware that HH had already passed away. HH's death had been the subject of another TBPS investigation.

[redacted] provided a copy of his report to Inspector Levesque and verbally shared the information he learned from GG with [redacted]. An alleged confession relating to SD's death should have mobilized the TBPS to treat this lead on a priority or urgent basis, if it was truly committed to learning the full truth about SD's death.

However, when [redacted] took over the investigation, he was unaware of GG's statement because it had not even been included in the Stacy DeBungee investigative file. Instead, it had been included in the HH investigation file. This cannot simply be attributed to an unfortunate misfiling. Adequate policing required, at the very least, that the new investigators be briefed on this development at the earliest stage of their involvement.

In addition to the above, the OPP found it problematic – and justifiably so – that the police received this initial information about an alleged confession on May 12, 2016, but it was not followed up on until June 30, 2016. In fairness, on May 13, 2016, [redacted] asked [redacted] to follow up with GG, but she was advised that GG was away for several weeks.

Ultimately, the matter was assigned to another officer to meet with GG. Again, this evidence was not treated as an urgent, priority matter, which is troubling given the nature of the information and the complaint already filed against the police.

Referenced Information

1. *Police Services Act* – Ontario Regulation 268/10 – **Schedule Code of Conduct**
2. *Ontario Human Rights Code and commentary*

Investigators

Evelyn Wayne
Mark Sandler