

Complainant(s): Brad DeBUNGEE

Jim LEONARD

Complaint Number(s): E-201603181148379843

E-201603181117037812

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.

and	. The officers told the family that
SD's death was not classified as foul play a	nd that further information would be provided by
the Coroner.	
When pressed with further questions,	informed the family of a theory that
SD had passed out unconscious, simply ro	lled nine to 10 feet down the riverbank into the
river and drowned.	

They spoke to three officers identified as



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.

Investigative Report

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.

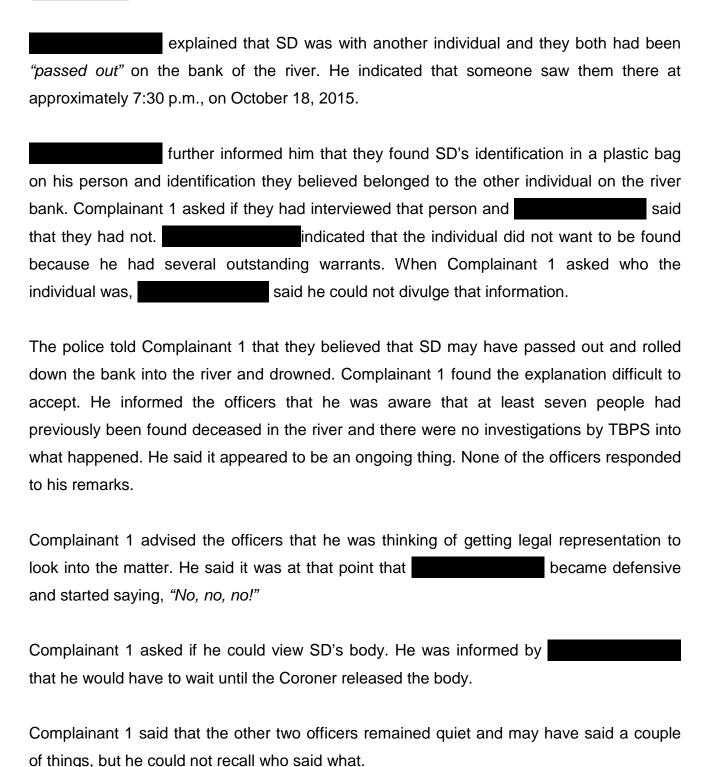
Complainant 1 said that he was not familiar with any of the people who were reportedly with SD the night prior to his death. His nephew had mentioned one of the people and he thought she was "shady" and might have been a member of a gang.



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 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
and were
present.
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 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.







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,	"looked as though
he was going to get up and go after him." He said	made a sudden
movement, but he was ready and prepared to defend himself if necessary	<i>/</i> .
At the conclusion of the meeting, Complainant 1 said he extended his	hand to
and thanked him for his time and effort. He said	would not
shake his hand. Complainant 1 continued to hold his hand out and	
reluctantly shook his hand. then told him to call if h	ne had any further
questions.	
Following the meeting, Complainant 1 and his family attended the are	ea where SD was
found. After approximately five minutes of being at the location,	arrived
and told them that he would show them where SD was discovered. Com	nplainant 1 found it
strange that happened to show up at the location t	he same time that
they were there.	
Complainant 1 explained that the reason he went to the location where	OD (a)
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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.



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 said the body was found. Complainant 1 said that he did not observe any evidence that indicated SD had rolled into the river.

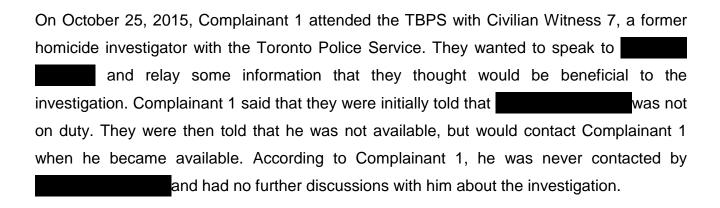
Complainant 1 was advised by that the Coroner was going to conduct an autopsy on October 22, 2015, and he would need to talk to the Coroner directly if he had any further questions.

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."





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.

Investigative Report

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.

Investigative Report

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 confidents 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.

Investigative Report

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.

Investigative Report

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.

Investigative Report

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.

Investigative Report

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

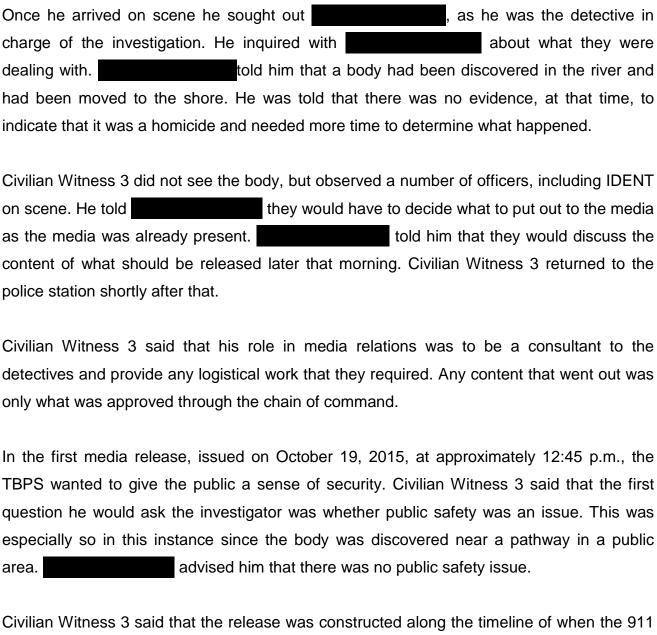
Civilian Witness 3 provided a recorded interview with the OIPRD on February 9, 2017. The following is a summary of the relevant portions of the interview.

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.

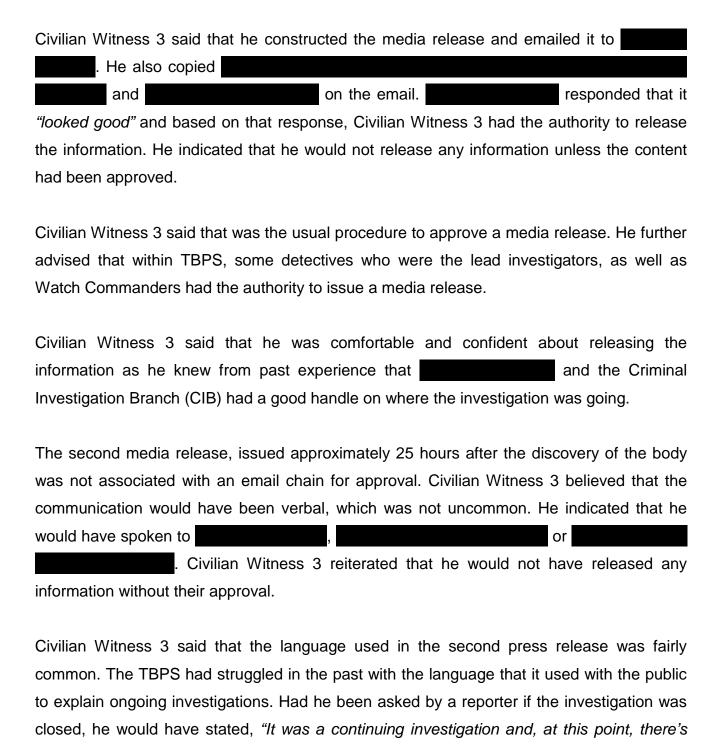
Civilian Witness 3 said normally the police constable that reported to him would attend the scene; however, she was not on duty that day and he attended in her absence. He thought there was a strong possibility that the media would attend the scene because the death had occurred in a public location.





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.





nothing to indicate it's going to be a criminal matter."

OPPO

Investigative Report

Civilian Witness 3 was not sure what level of confidence 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.

Investigative Report

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.

OPPO

Investigative Report

Since the initial contact, the police did not communicate with Civilian Witness 4 until a year later when 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.

Investigative Report

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.

OPPO

Investigative Report

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, 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.

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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 Wit	ness 6 and their aunt
attended TBPS on October 21, 2015, to meet with	the officer in charge
of the investigation. When they arrived, they were told that	was
unavailable until later that afternoon. At approximately 1 p.m.,	and
and met with them.	

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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 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

. 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.

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"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 requested that call him back so he could share that information. He said that he had never been contacted by real 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.

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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.

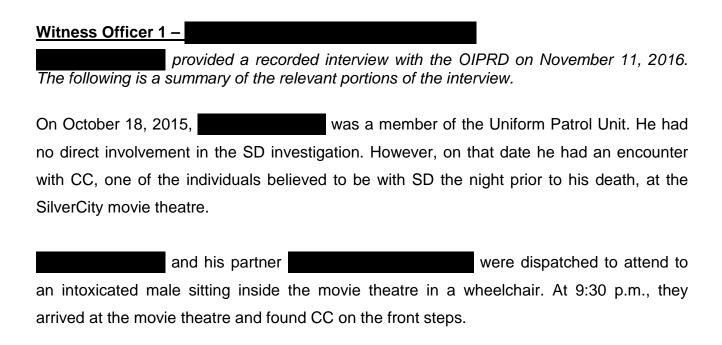
Civilian Witness 7 said that timelines for obtaining evidence were always paramount and went to the relationship with the family and the community. He stated that you only get one chance at building rapport and trust with the family and that was why police should always contact the family first and not 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.

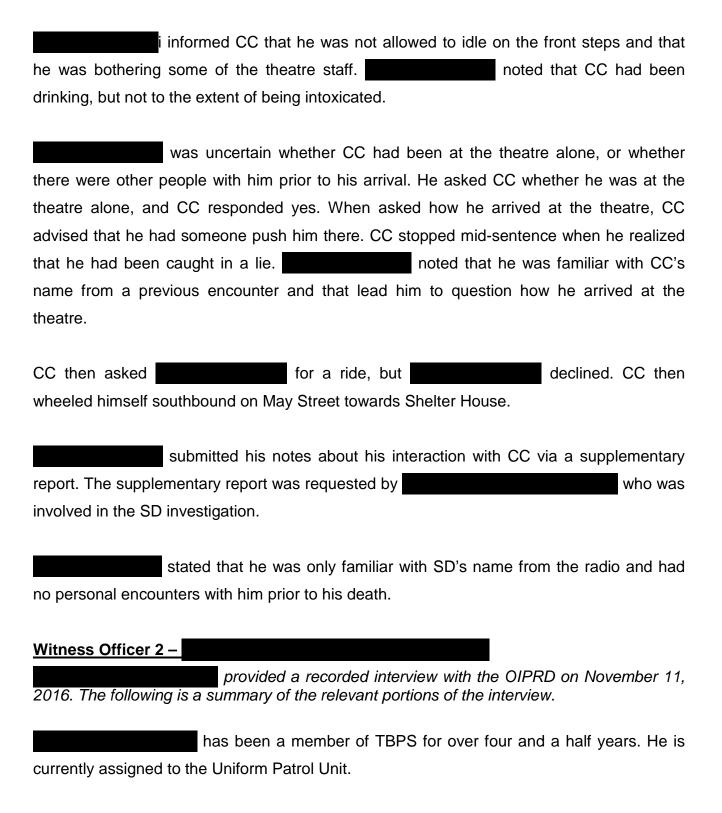


Civilian Witness 7 thought that one of the biggest steps that were missed was the lack of a family liaison person to communicate with and provide information to, and more importantly, ask for information from the family. He found it extraordinary that no one from TBPS spoke to SD's common-law spouse, 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.



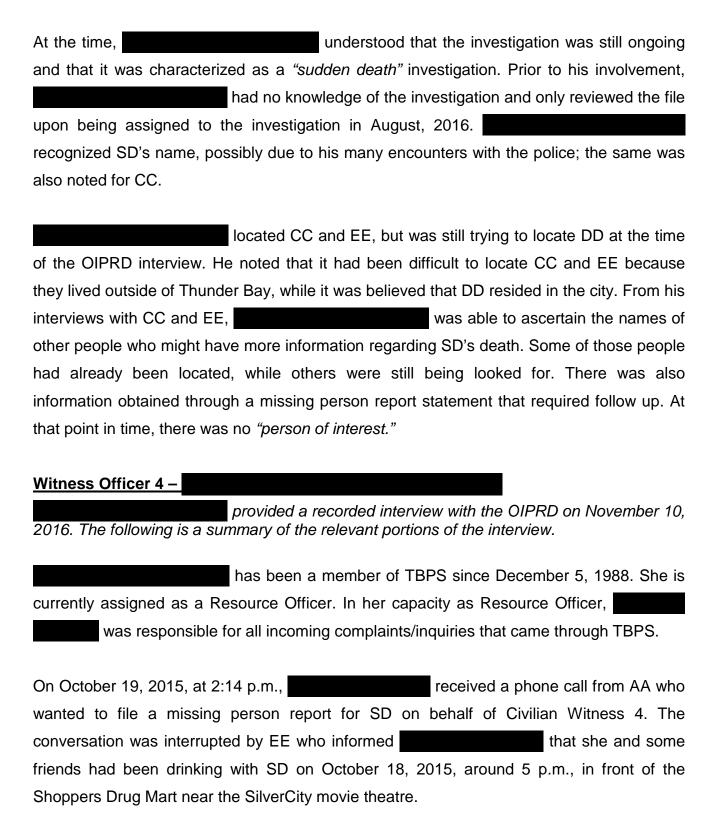




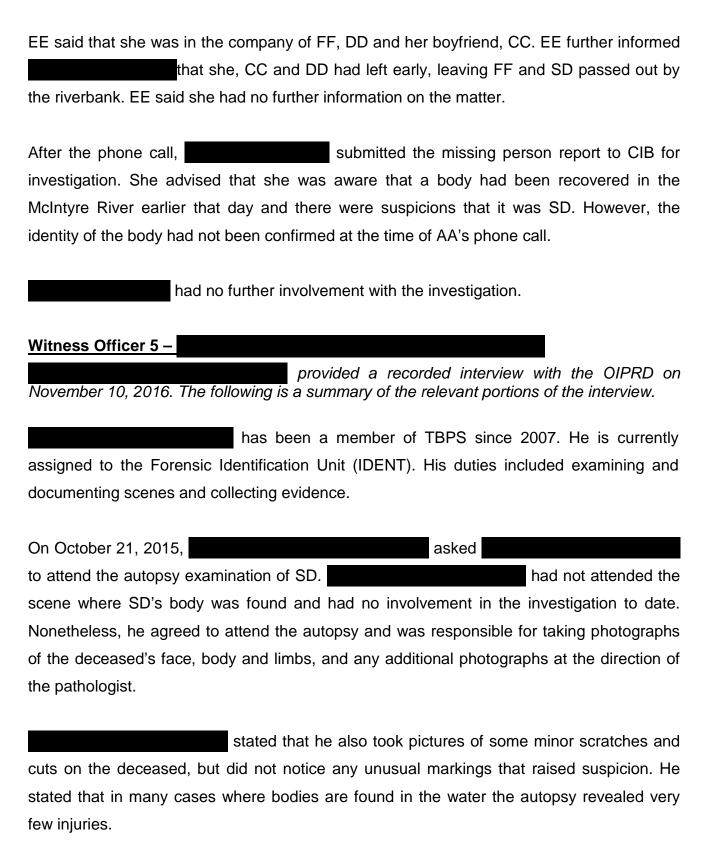


had no direct involvement in the SD investigation. On October 18, 2015,
he had an encounter with CC at the SilverCity movie theatre.
call that there was a male at the SilverCity movie theatre who appeared to be intoxicated
and was unwanted on the property.
around 9:30 p.m., and found CC sitting alone in a wheelchair.
CC told that he had arrived at the theatre under his own power.
recollection of how CC said that he arrived at the theatre differs from that of
, 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.
found that CC was not intoxicated enough to pose a threat to himself or
the public.
CC asked for a ride from and and but they refused and
explained that the police cruisers were not equipped to transport wheelchairs.
Witness Officer 3 –
i provided a recorded interview with the OIPRD on
November 10, 2016. The following is a summary of the relevant portions of the interview.
has been a march or of TDDC airea. Assessed 2000, He is
has been a member of TBPS since August, 2006. He is
currently assigned to the CIB.
In August 2016, and
requested that a long with , 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.





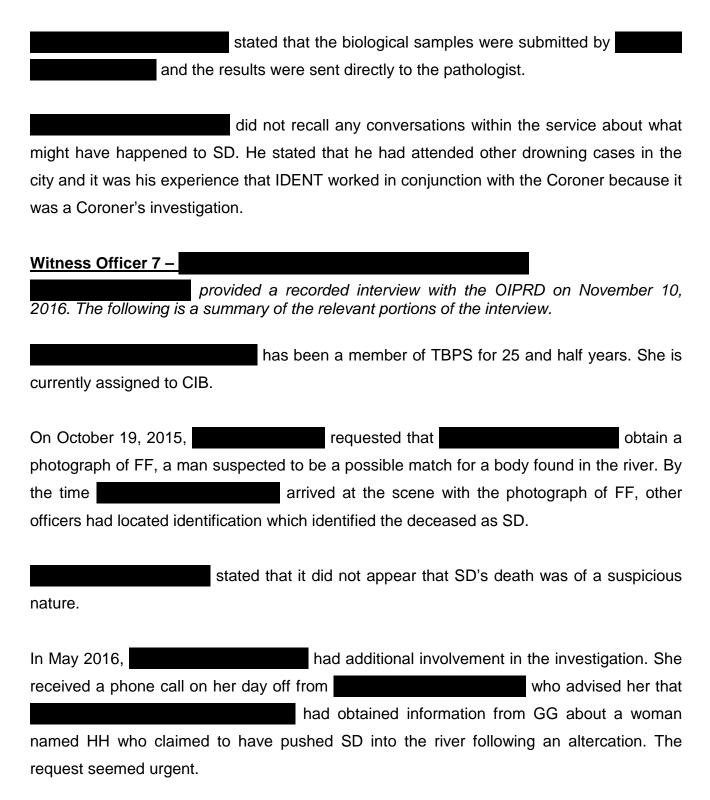




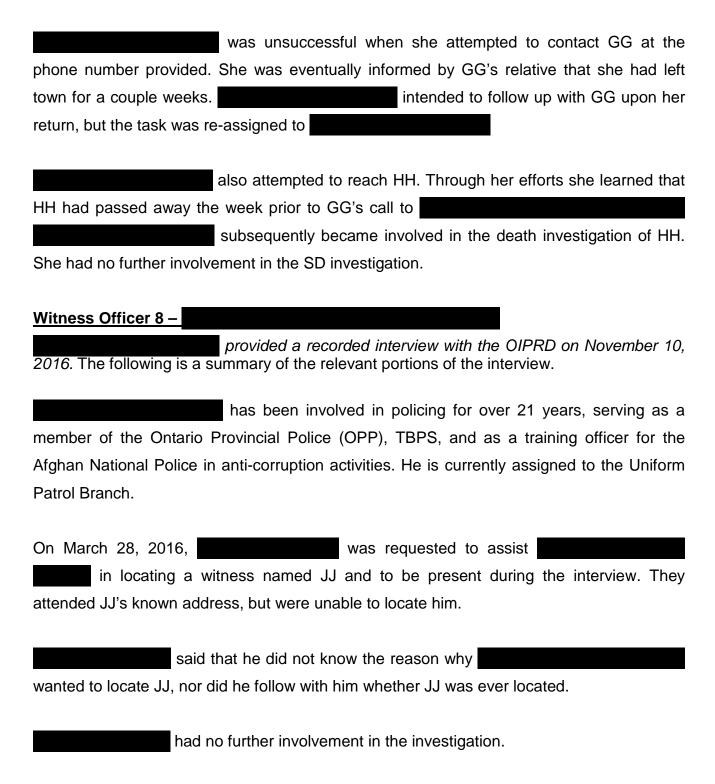


said that he took approximately 30 to 50 photographs during the autopsy. The photos were uploaded to the police database and the samples collected were sent to the Centre for Forensic Sciences. He had no further involvement in the investigation. Witness Officer 6 – provided a recorded interview with the OIPRD on December 2, 2016. The following is a summary of the relevant portions of the interview. 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. did not attend the scene where SD was located. On October 21, 2015, he attended the autopsy, along with 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 said that he and testing. 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. 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.

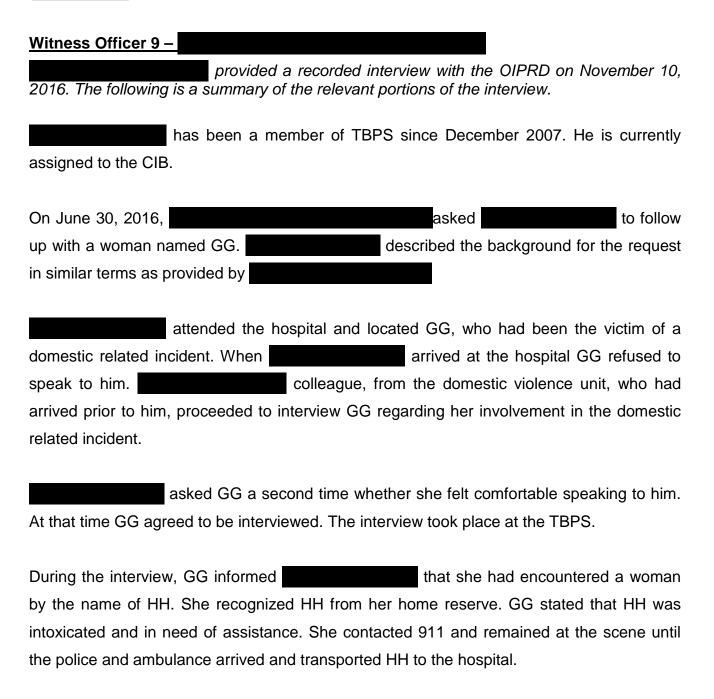






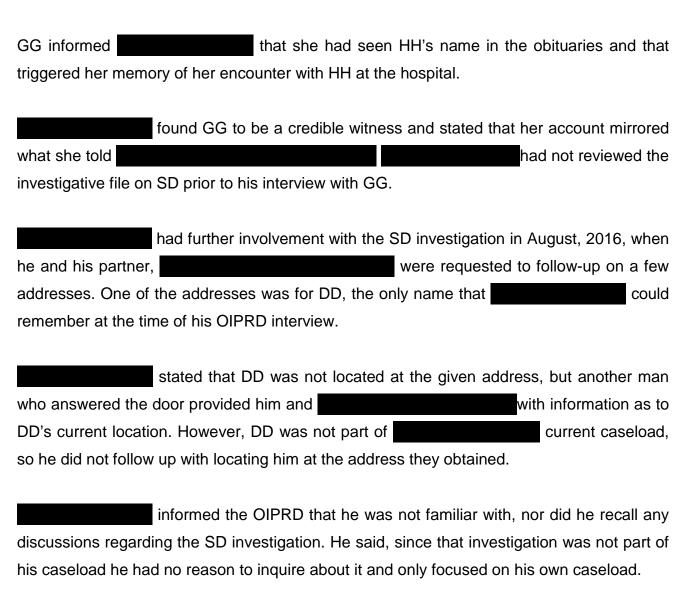








Later that same evening, GG went to the hospital with her sister for an appointment and noticed HH on a stretcher still intoxicated because she had a hidden bottle of Listerine in her pocket. GG approached HH and asked her why she continued to drink. HH replied that she was having nightmares and visions 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.



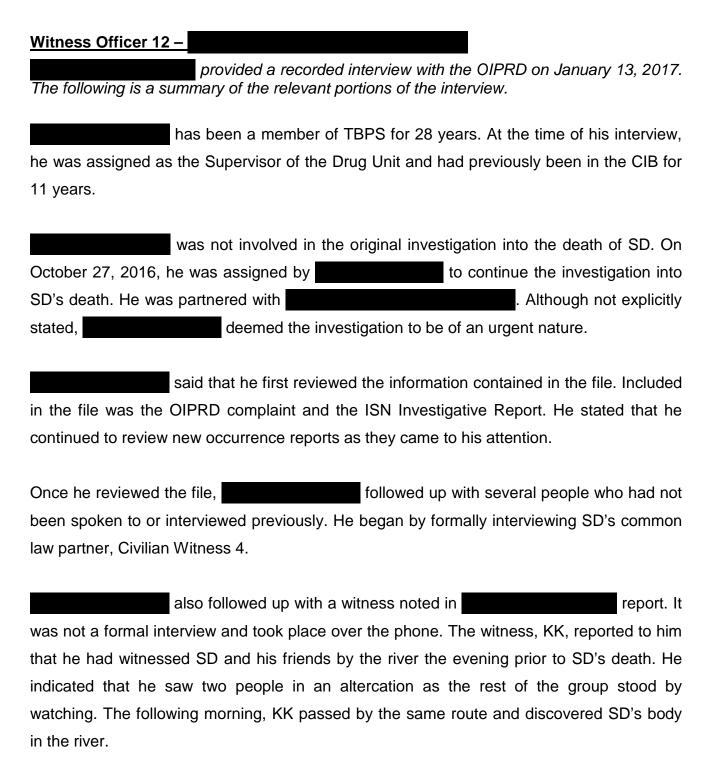


Witness Officer 10 –
provided a recorded interview with the OIPRD on December 2, 2016. The following is a summary of the relevant portions of the interview.
has been a member of TBPS since June 1995. When he was
interviewed by the OIPRD, he was assigned to the CIB.
On October 19, 2015, at 9:36 a.m., was assigned by
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.
had no further involvement with the investigation.
Witness Officer 11 –
provided a recorded interview with the OIPRD on January 13, 2017. The following is a summary of the relevant portions of the interview.
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, 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.
had a conversation with regarding the identification as there
was some concern about the identity of the deceased.
did not attend the scene.

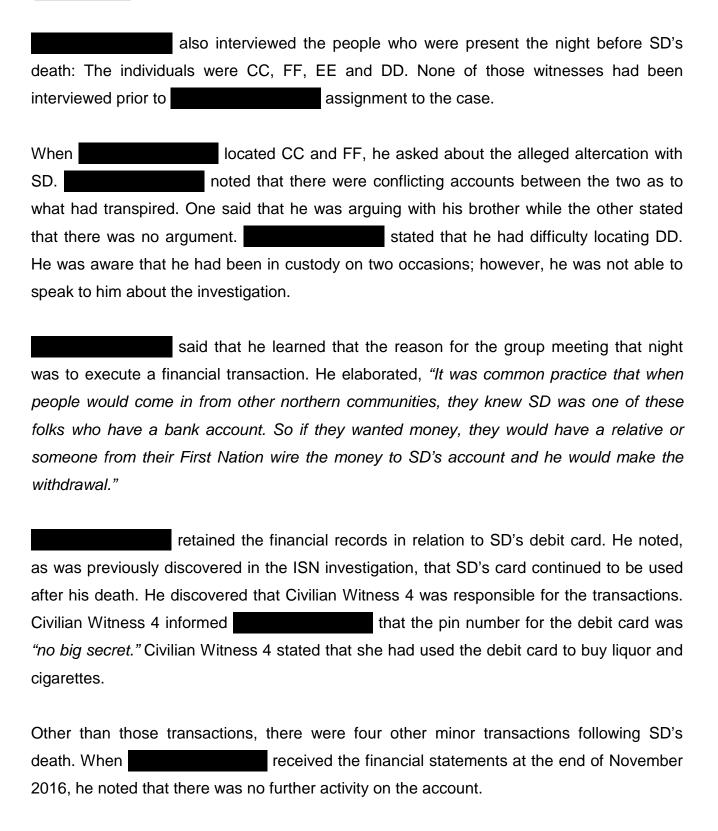


was notified about the press release concerning the
investigation, but he was not consulted about the information contained in the release. He
said that any information that was included in the media release was provided by
· · · · · · · · · · · · · · · · · · ·
On May 12, 2016, was contacted by GG, who 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, 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 with the
knowledge that it could be helpful in the SD investigation. He also verbally shared the
information he learned from GG with However, when
was re-assigned to the SD investigation, he was unaware of GG's
statement because it had been included in the HH investigative file rather than the SD
investigative file.
stated that he had no further involvement in the SD
investigation.

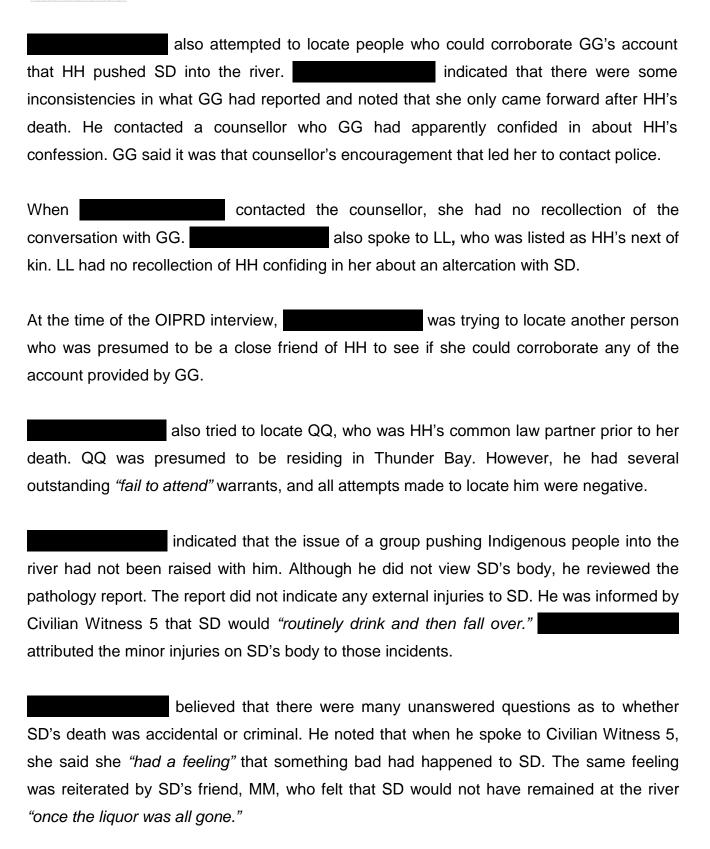




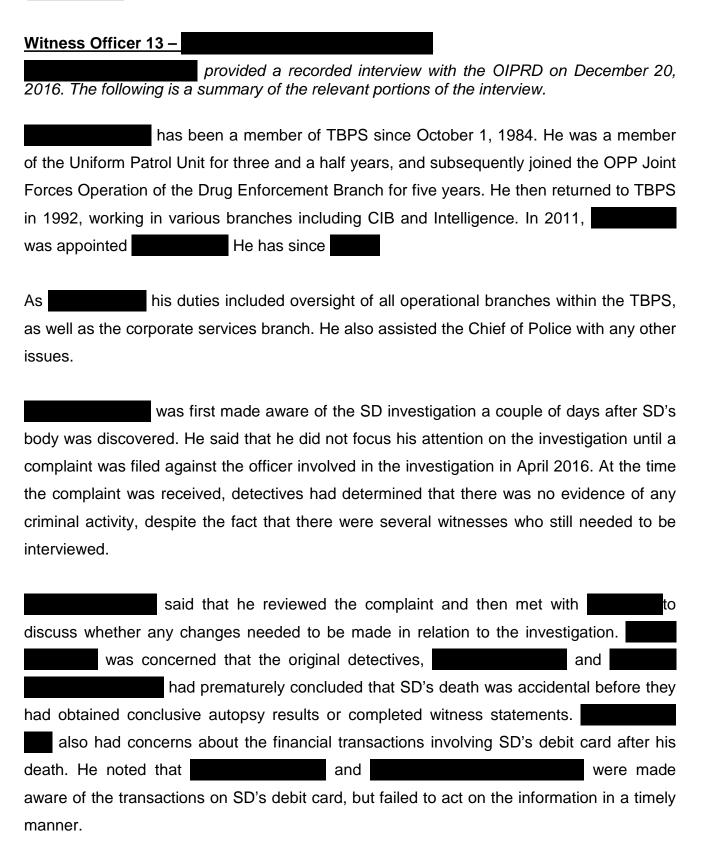




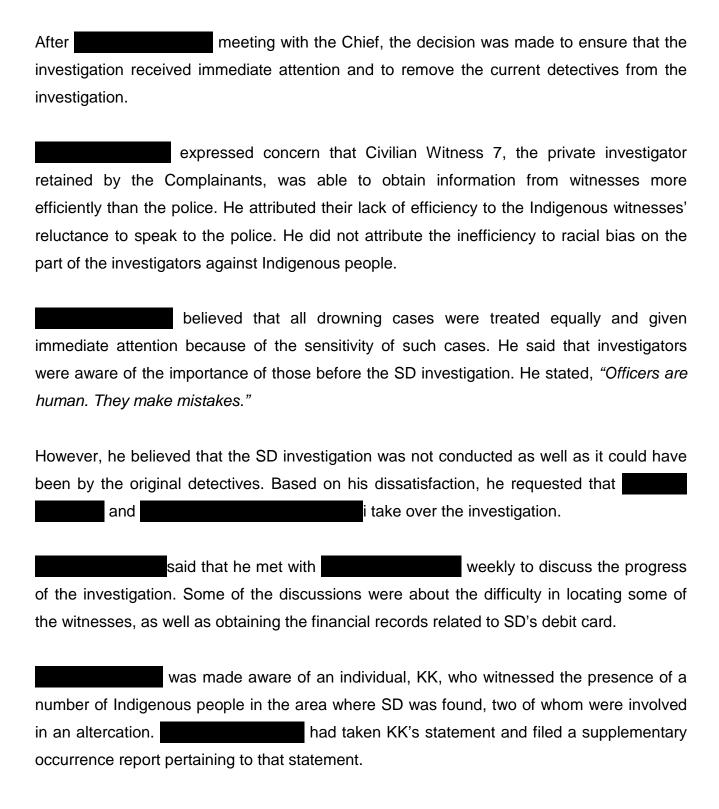














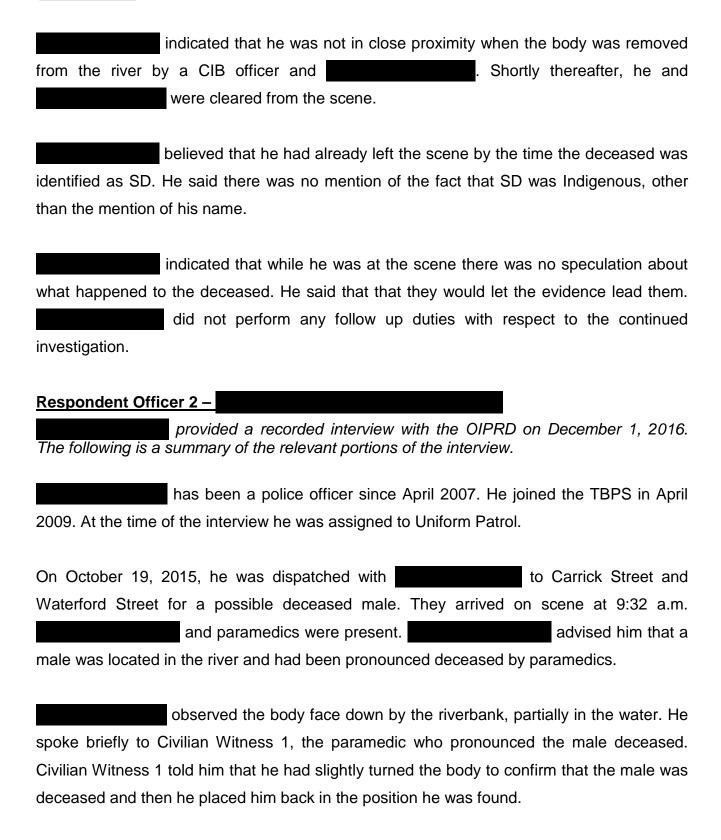
said that	updated him on the progress of the
investigation and informed him that he had	followed up with the witnesses and the other
individuals related to the investigation.	
said that he did not involve	himself further in the investigation.



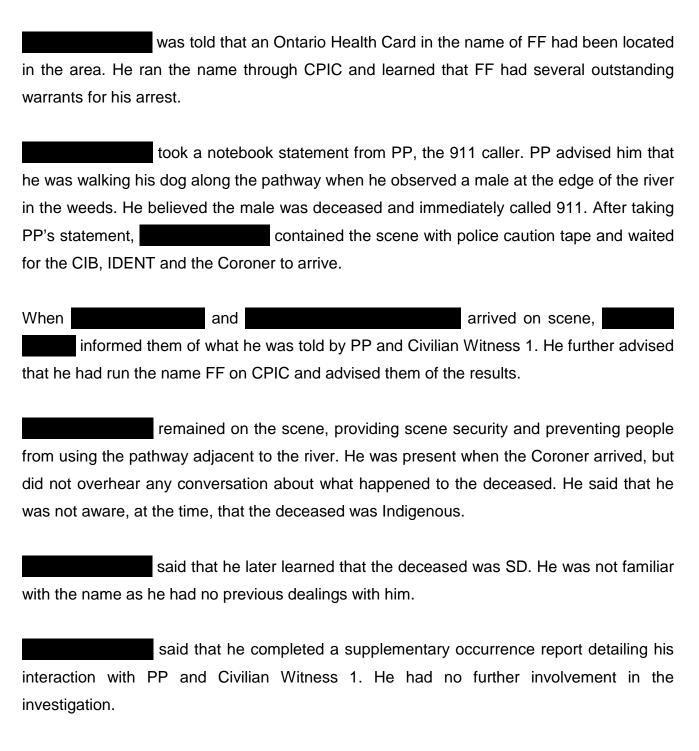
Summary of Statements – Respondent Officers

Respondent Officer 1 –
provided a recorded interview with the OIPRD on December 1, 2016. The following is a summary of the relevant portions of the interview.
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, was partnered with . They
were dispatched along with to respond to a body in the river at Carrick
Street and Waterford Street. When and and arrived at the scene,
was already there with paramedics. The male had been pronounced
deceased by the paramedics on scene.
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.
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.
advised that attended the scene. He
requested that he, along with and and , secure the
scene. Support services were called in, including CIB, IDENT and the Coroner.
noted that and
attended from CIB. The IDENT officers were
and and

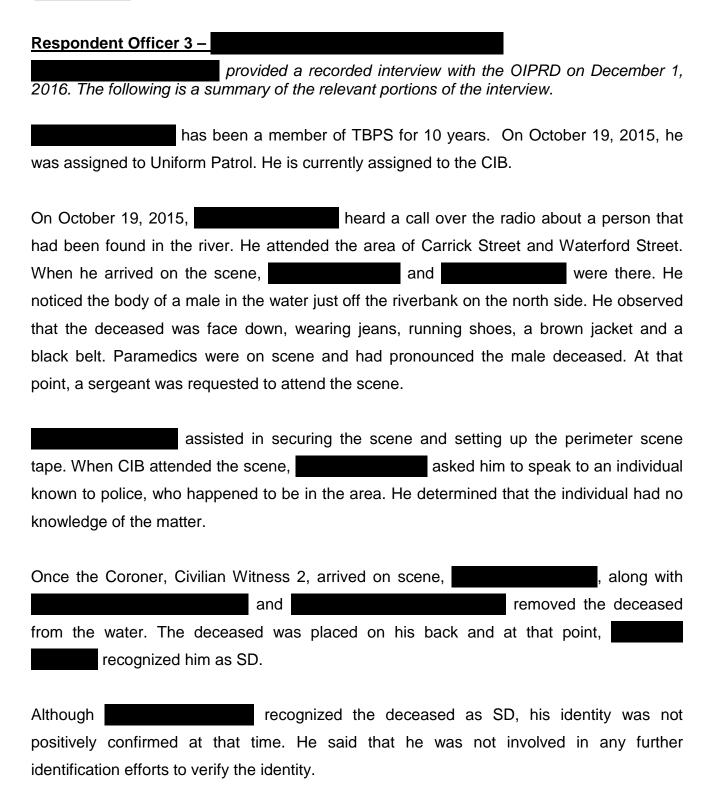




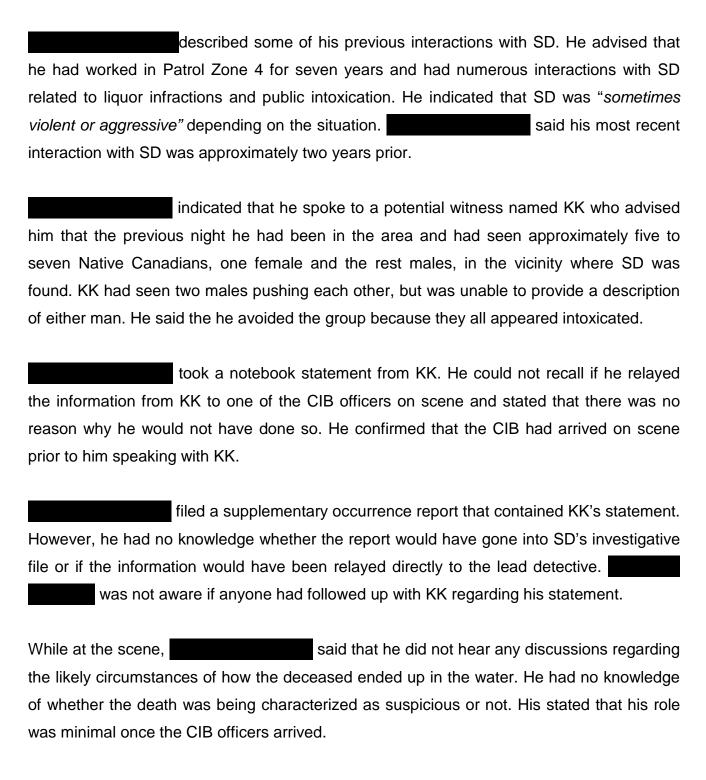




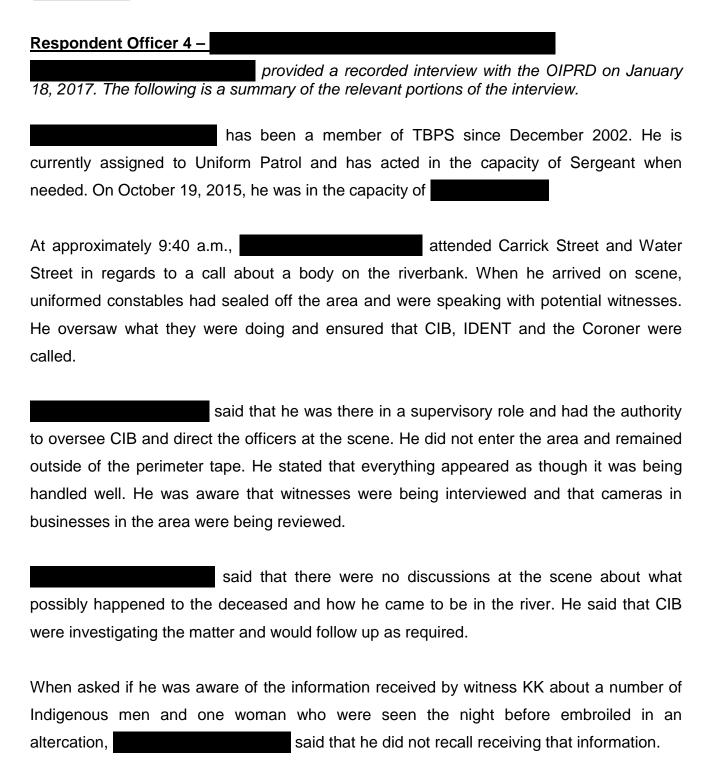




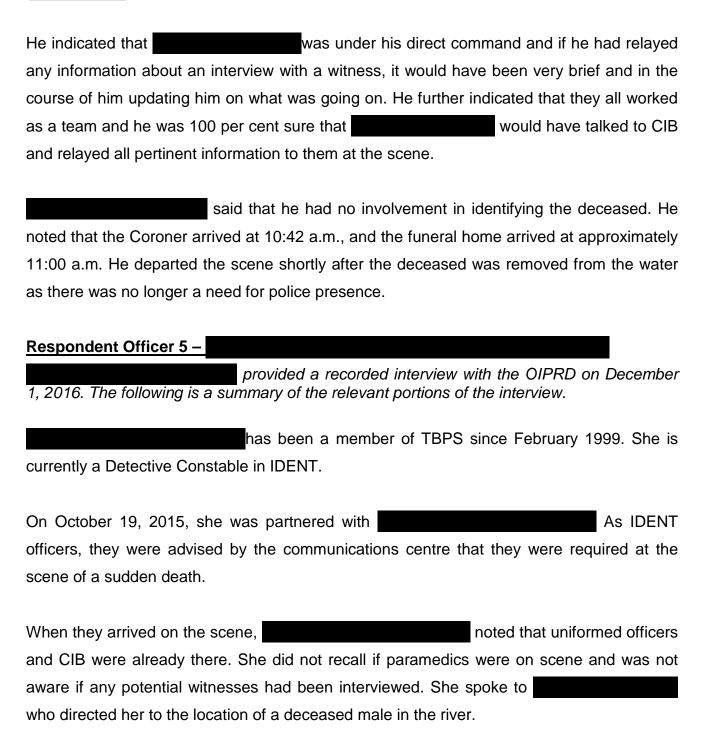




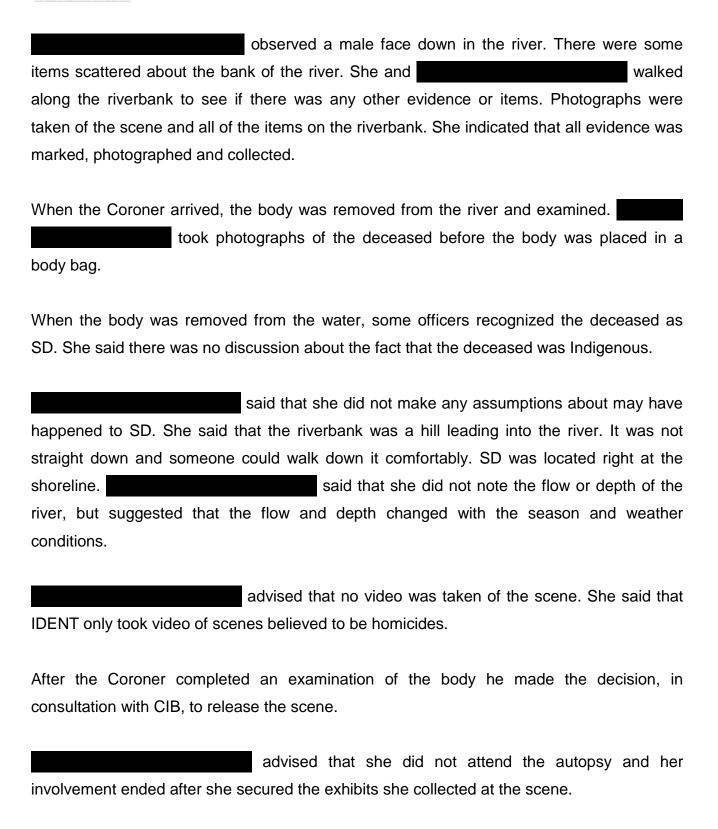




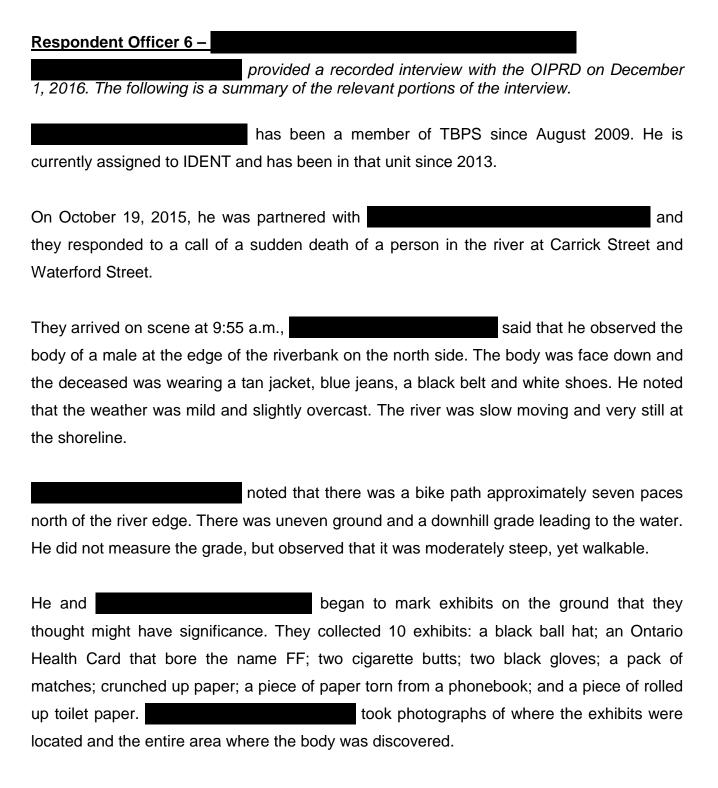






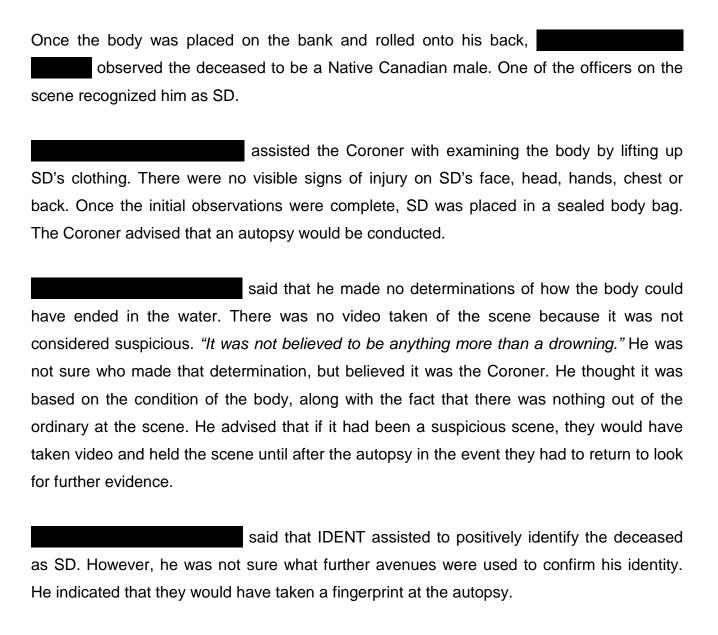




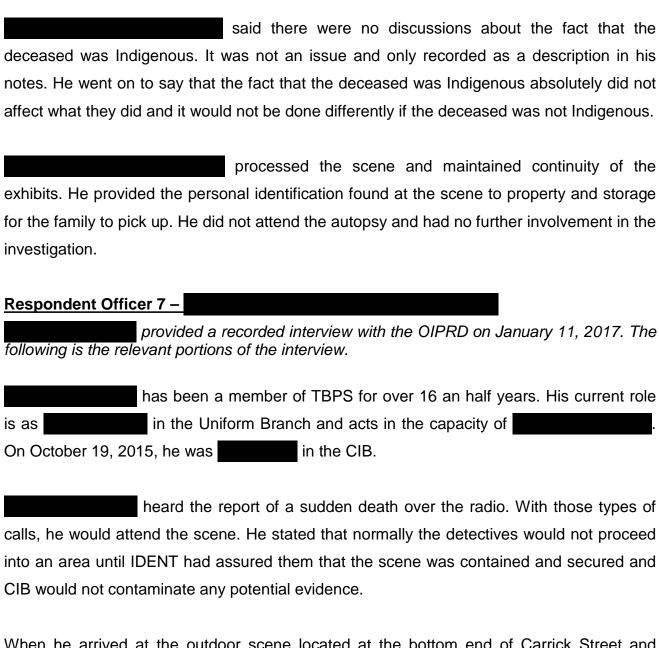




At 10:43 a.m., the Coroner arrived on scene. The body was removed from the water. At that time, a zip lock bag was found near the deceased's head. Inside the zip lock bag was an Ontario Health Card belonging to SD, two winner's circle cards, an air miles business card, a \$10 phone card and a handwritten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







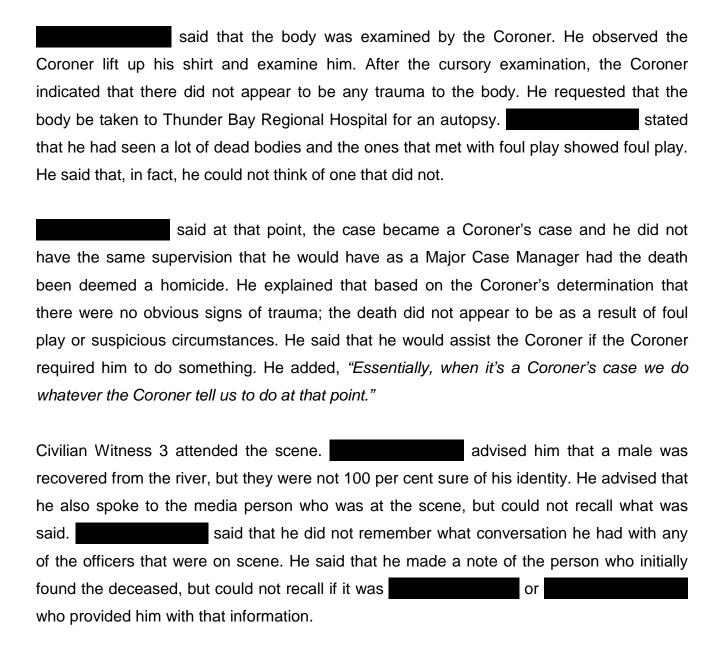
When he arrived at the outdoor scene located at the bottom end of Carrick Street and Waterford Street, IDENT and uniformed officers were there. The area had been cordoned off with police tape. He did not enter into the scene, but from his vantage point he observed a deceased person in the water.



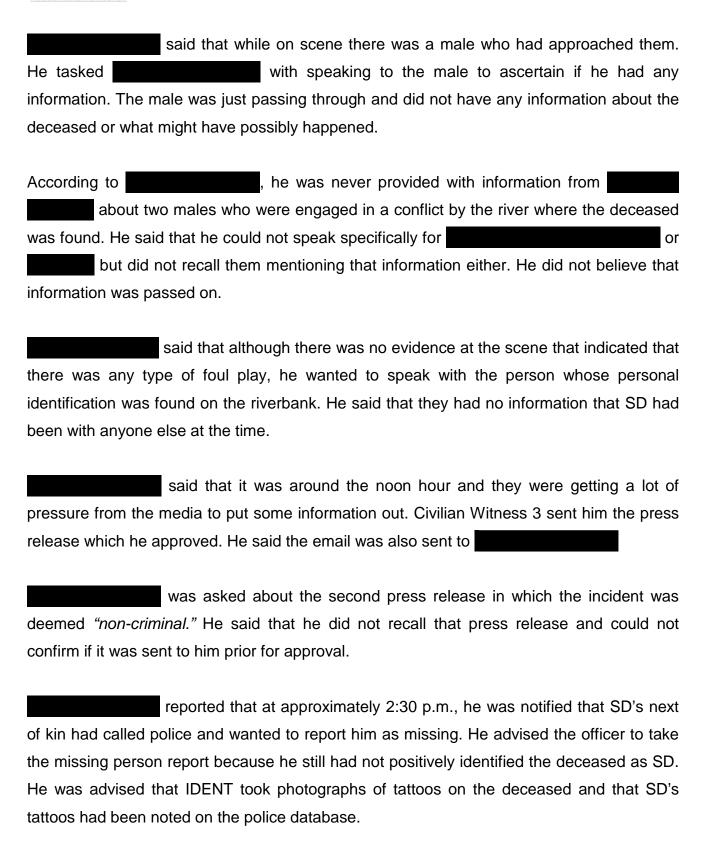
said that paramedics were no longer there as they had pronounced the
person deceased and no life saving measures were undertaken. He said that as the IDENT
officers did their work, he, and waited for the
Coroner to attend.
described the area as a regular concourse for foot and bicycle traffic. He
said 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.
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, thought that the identification possibly belonged to
the deceased.
While he waited for the Coroner to arrive,
the scene. He contacted 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. and 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. 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.
said that they were not 100 per cent sure that the deceased was SD.



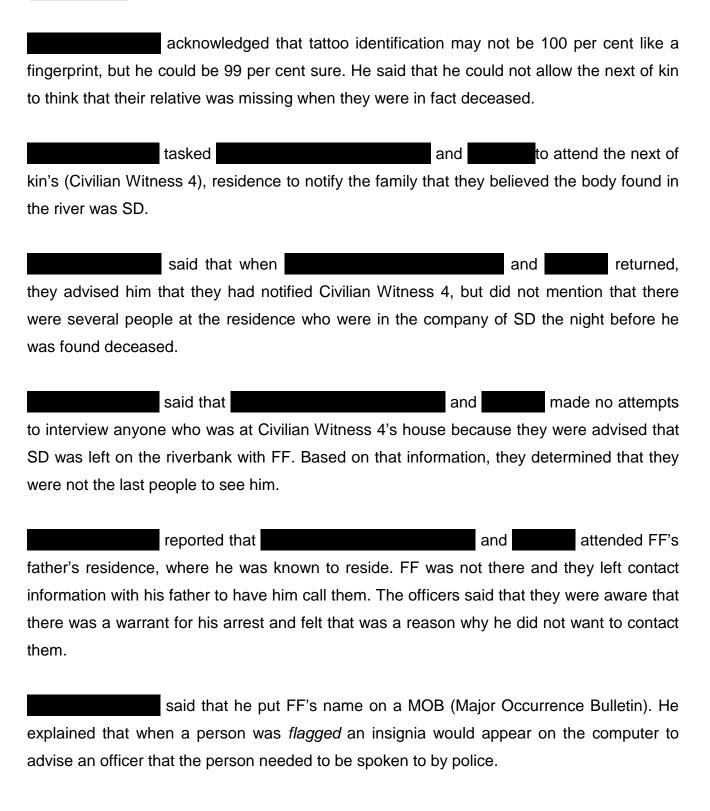
He said that although some officers had identified him, he preferred fingerprints to make a positive identification. At the autopsy, they would obtain fingerprints that would be compared by IDENT officers to confirm the identity.



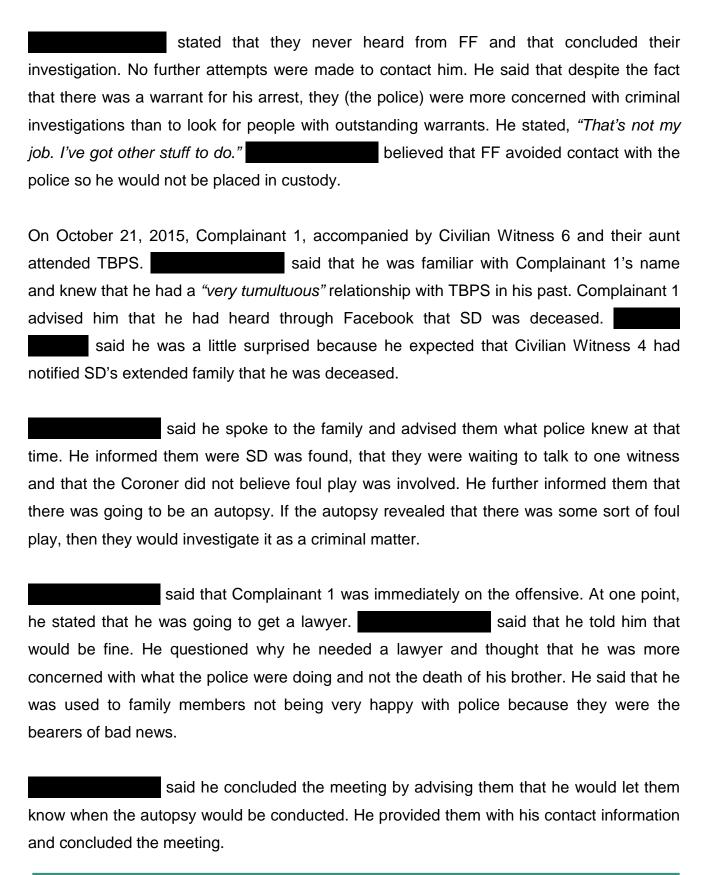








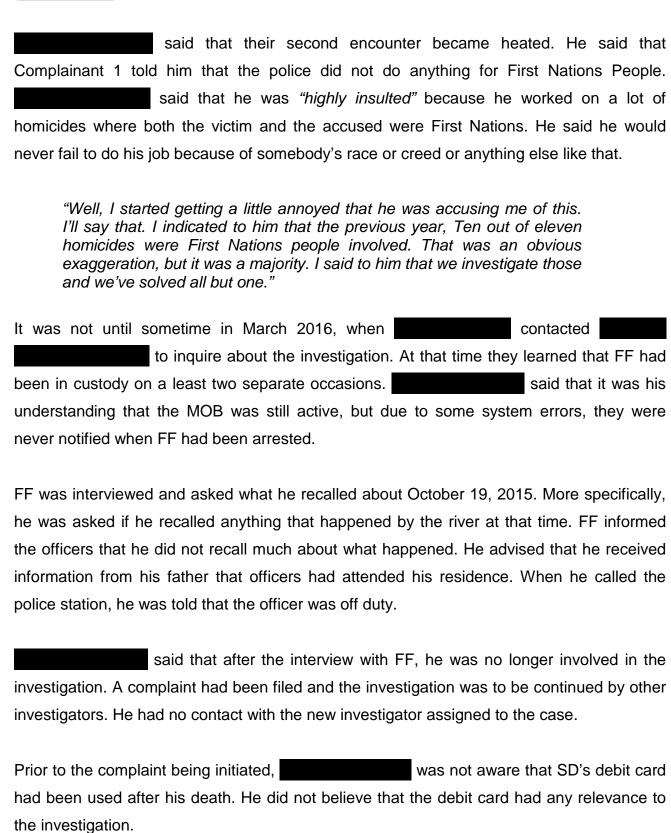




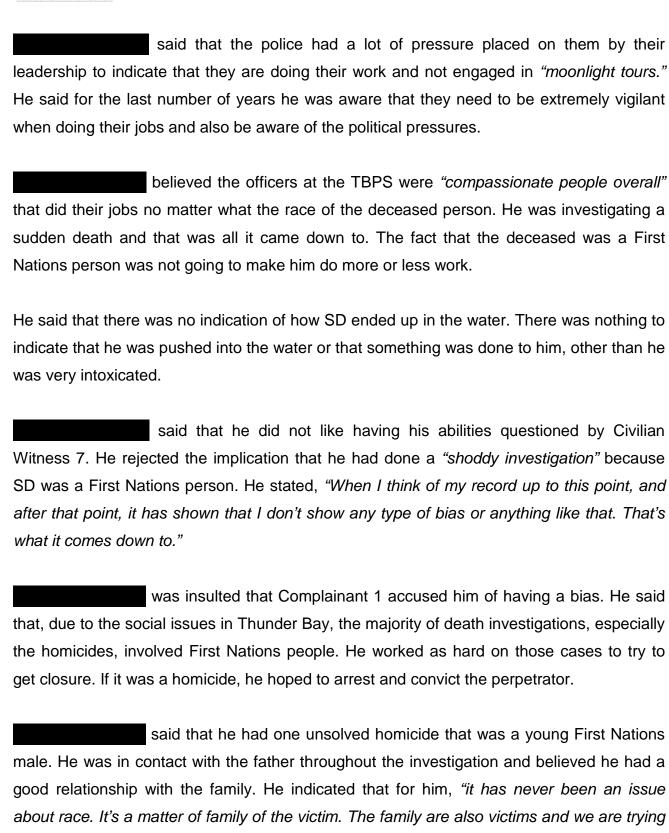


said that later that afternoon he saw Complainant 1 and his family by the river. He indicated that he was not that familiar with First Nations' culture, but he knew from previous investigations that the family would go to the location where their next of kin passed away. He decided to show them where 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. 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 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. 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. 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 told him that he would have to file a Freedom of Information (FOI) request in order to obtain any documents.





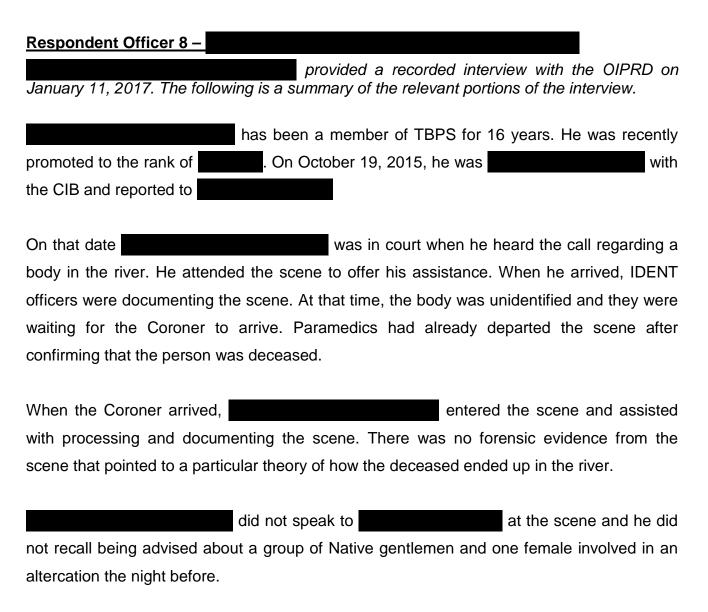




to get some closure for them."



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.





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. 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. detailed him and to attend
Civilian Witness 4's apartment to notify her of the SD's death.
According to was the 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.
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
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.



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.
was aware that FF's identification had been found at the
scene. On October 20, 2015, he and attended FF's residence
to speak to him about the incident. He was not home.
card with his father who indicated that he would pass it along when he saw his son and
have him contact police.
believed it was that same day that
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, and and 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.
let them know that the deceased's common-law spouse was notified as his next of
kin.

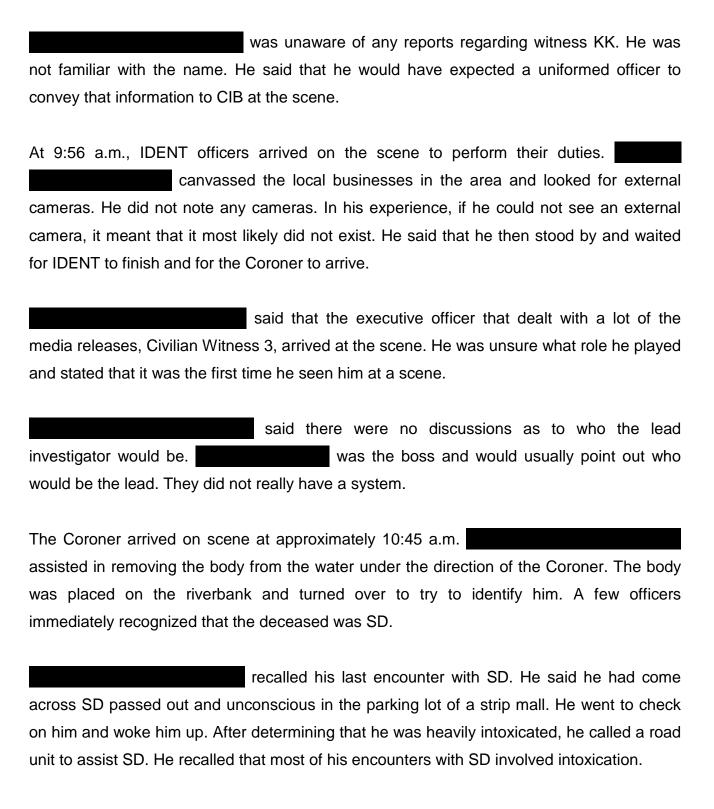


The family also called into question whether SD had been killed.
most of the talking and said that there was nothing to indicate that. Once the autopsy was
complete, if there was new information from that or from any other source pointing towards
criminal activity, they would launch an investigation and they would look into it further.
did not hear say that the investigation was
effectively completed or that no further work was to be done.
did not believe that 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
stated, "He may have rolled in. We don't know. We
may never know how he ended up there."
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, received a call from
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, stated, "That's a problem."
said he had no idea what he was referring to and did
not give him any direction at the time told that
he should speak with about the matter. He said in his 16 years of
policing, he had never received a call from at home. He felt as though
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



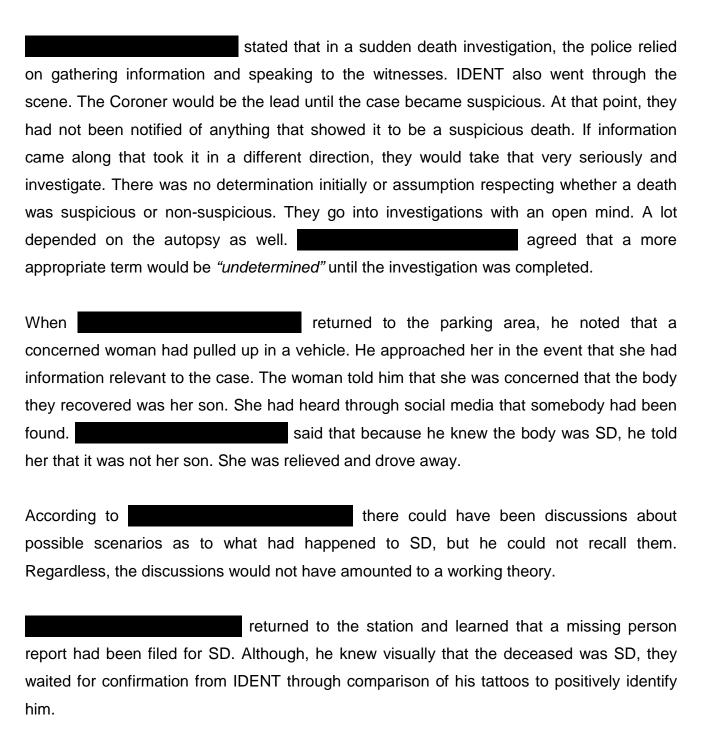
When	contacted	, he confirmed that FF was
still on the MOB. He further learned	d that FF had contact w	rith officers on a few occasions,
but CIB was never notified.		
On March 28, 2016,	and	attended the
district jail to interview FF. He said	that FF recalled very littl	e besides being intoxicated and
having a verbal argument with his	brother, CC that night	t. He did not recall specifically
drinking with SD. He remembered	that he left and walke	ed to JJ's house. That evening
		or JJ, but none of the occupants
knew who JJ was.	Ç	•
indica	ited that was his last inv	volvement with the investigation
and that he had not spoken to the ne	ew investigators assigne	d to the case.
Respondent Officer 9 –		
December 2, 2016. The following is	•	I interview with the OIPRD on and portions of the interview.
has b	peen a member of TBPS	S since 2006. At the time of the
interview he was assigned to the CII		
On October 19, 2015, he attended	the scene of a sudden	death with
When they arrived,		and the
were on scene.		
said	that he could see a boo	dy in the water at the bottom of
the hill. He noted that there was a	downgraded slope tow	ard the river. He did not notice
anything that stood out from the	scene that was forens	sically 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	s also advised that	spoke to the 911
caller, PP, who had discovered the b	oody.	



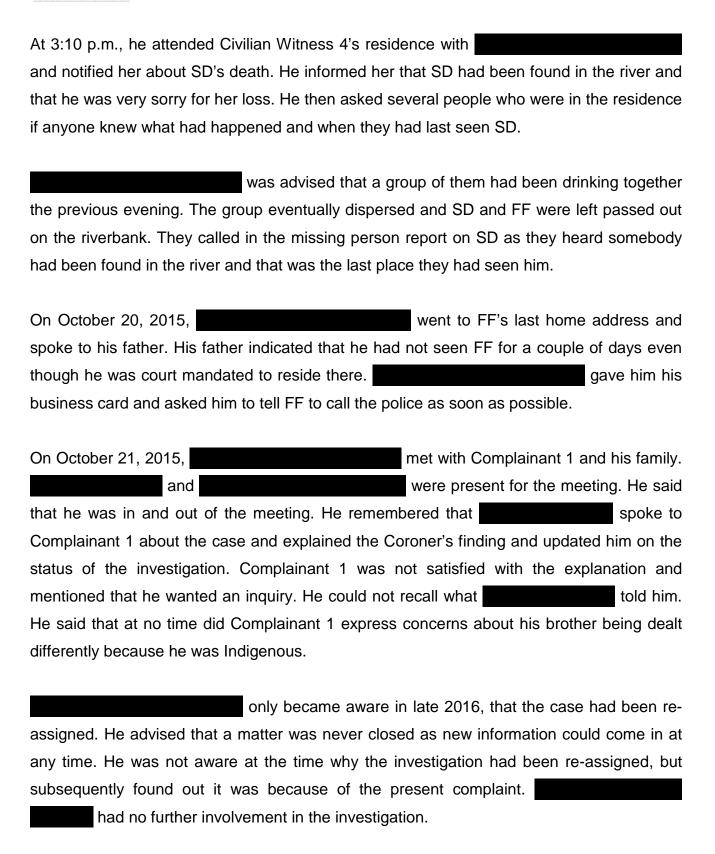




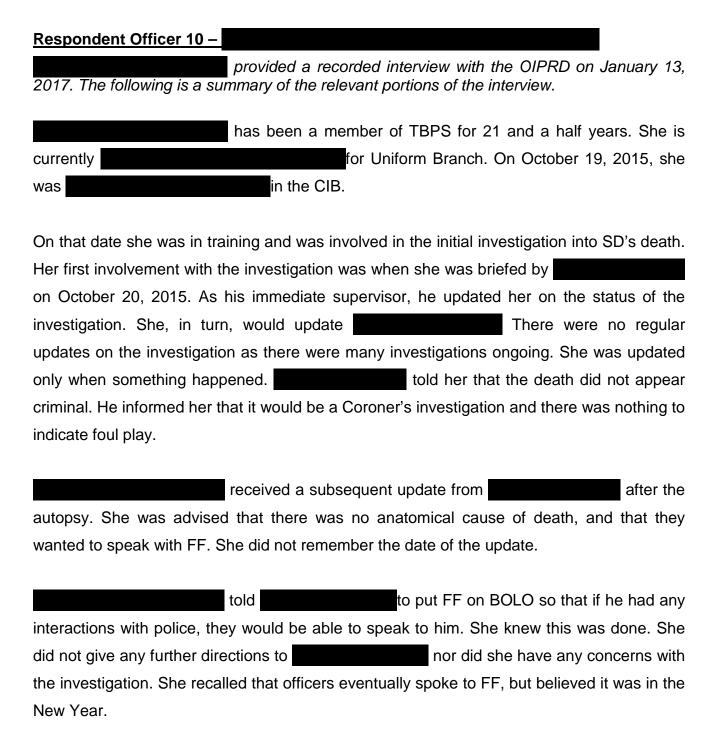
When the Coroner examined SD's body, no obvious signs of trauma were identified. There was nothing obvious other than the fact that SD was deceased. His body was then placed in a bag and tagged.



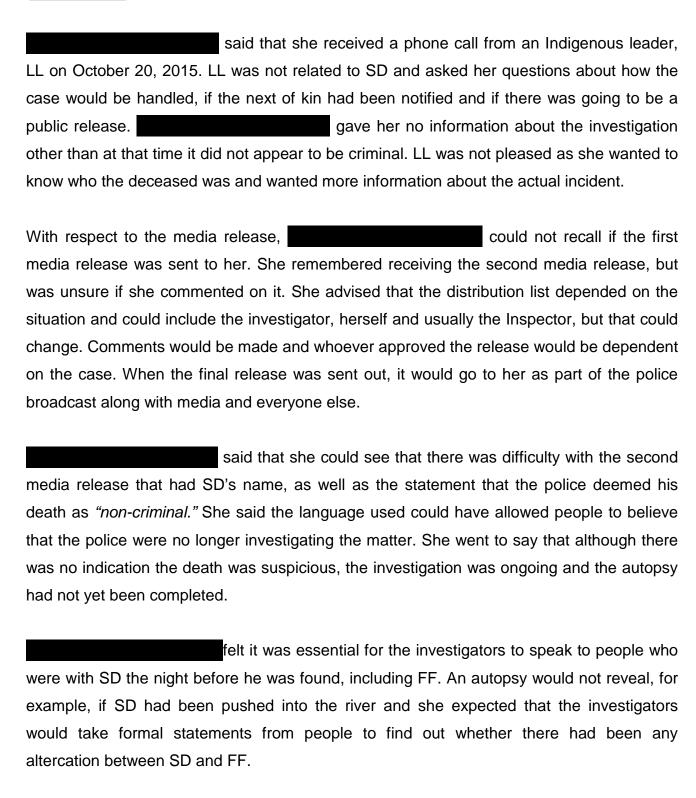




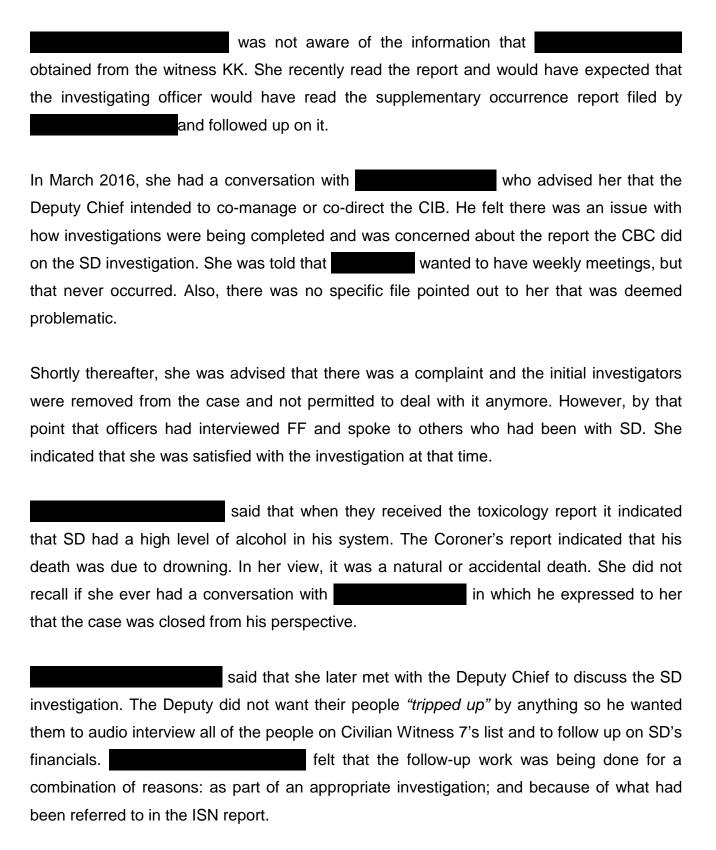








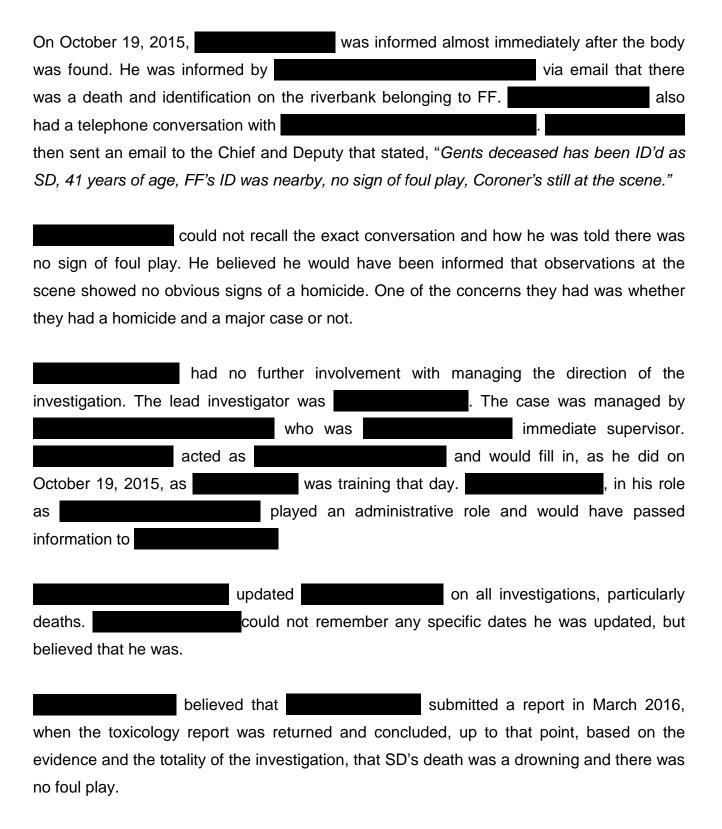




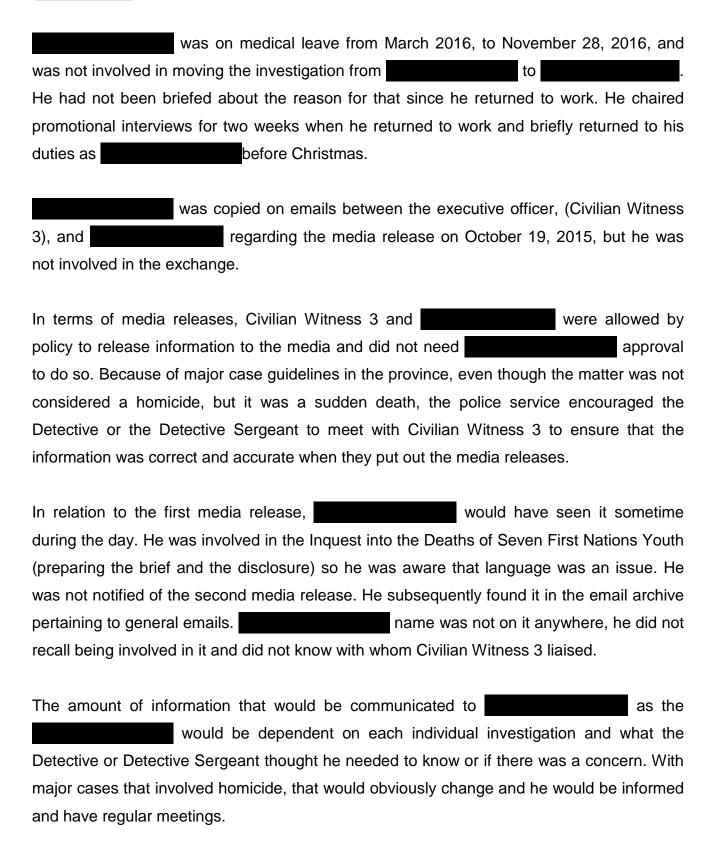


stated that the investigators who had worked on the SD
investigation had worked on "numerous deaths of Aboriginals, Caucasians, Hispanic, and
African-Americans and they do an excellent job." Although
thought that the media release could have been done differently, she believed that the
conclusion they arrived at, indicating that the death was non-criminal, was accurate.
Respondent Officer 11 –
provided a recorded interview with the OIPRD on January 11, 2017. The following is a summary of the relevant portions of the interview.
has been with TBPS for almost 32 years. He had been
of the CIB since 2009, and had recently taken on the role as
as of 2017. He and subsequently before
the completion of the OIPRD investigation.
As, 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. 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.
and involved avanisht annuaries the budget and analism asses
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.
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. believed there had been 43 homicides since 2009. Only two were
unsolved which indicated a very high clearance and conviction rate.

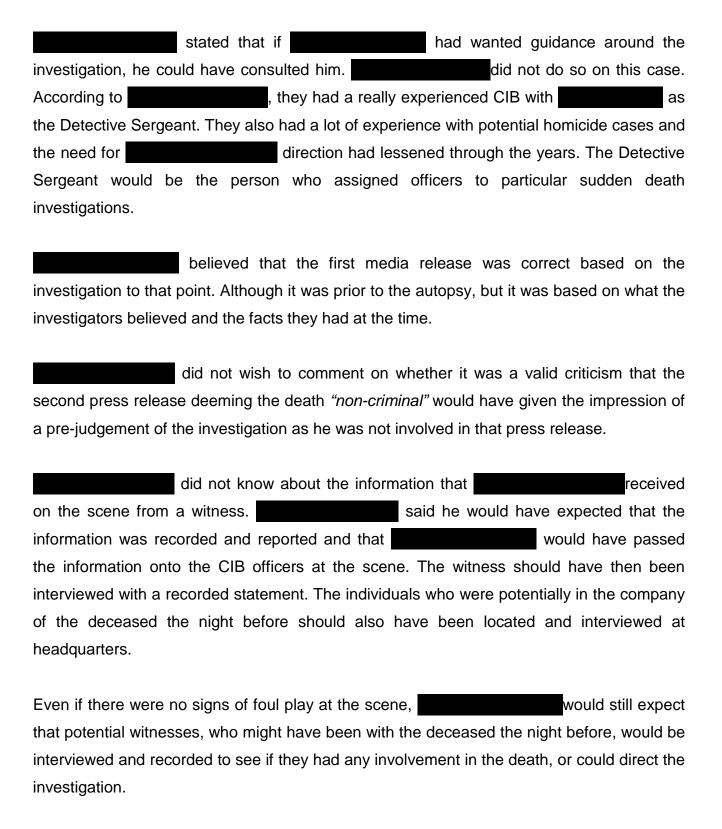














The information that there had been a physical altercation between two men would have helped direct their investigation as well as have had a bearing on whether there could have been a criminal element to the death.

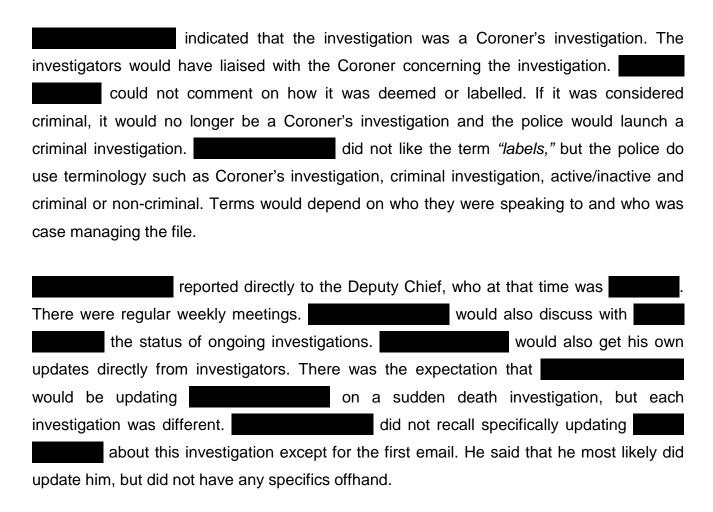
was following the Inquest into the Deaths of Seven First Nations Youths at the time and watched some of his colleagues testify. It was a big topic of conversation in the office on a regular basis. He had been involved in some of the investigations. He could not remember specifically whether the Inquest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

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.

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. 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."







Other Evidence

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

On January 12, 2017, 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

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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

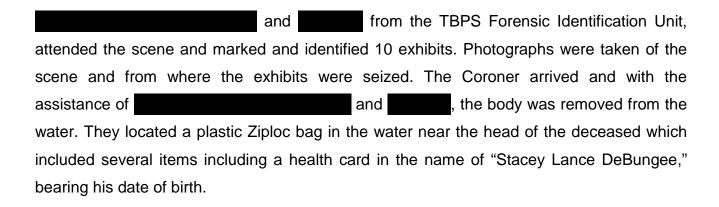
The OPP found that the responding officers conducted their duties efficiently and in accordance with TBPS policy when first called to the scene. The body was determined to be deceased and officers secured the scene and the CIB was called.

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



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. 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.

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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

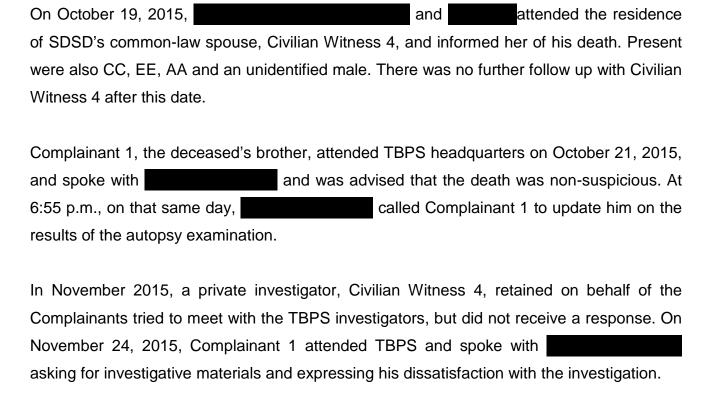
Two media releases were issued: on October 19, 2015 at 12:45 p.m., and a second one on October 20, 2015 at 10:15 a.m. The first one stated "An initial investigation does not indicate a suspicious death." The second release identified the deceased and stated that "Mr. DeBungee's death has been deemed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



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

and

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

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.

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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.

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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.

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- 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.

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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.

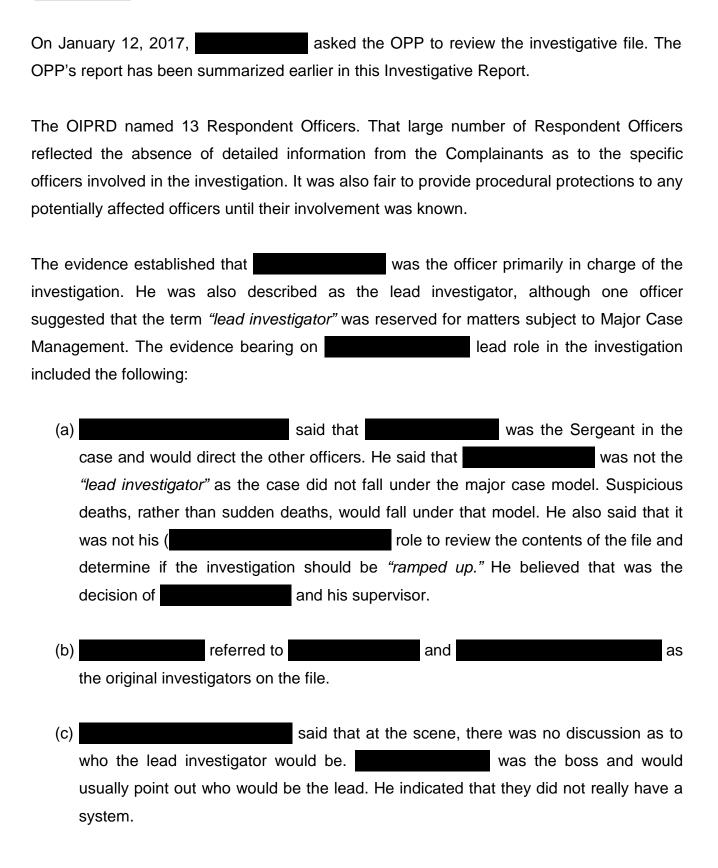
On October 21, 2015, the autopsy was conducted. Very little was done to investigate the death between October 21, 2015, and January 29, 2016, when the autopsy report formally attributed SD's death to drowning with alcohol intoxication as a contributing factor.

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.

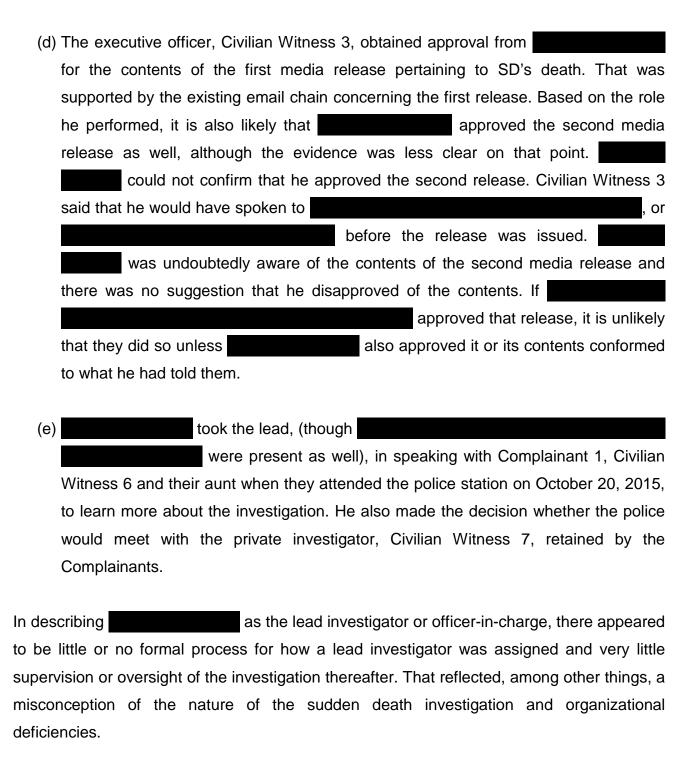
On March 28, 2016, the police took further investigative steps when they interviewed the person believed to be last seen with the deceased, referred to as FF.

The complaint to th	e OIPRD and concerns on	the part of TBPS's senio	or management,
particularly	, about how the TE	BPS's investigation had b	een conducted,
prompted the reassi	gnment of the file to	and	
The OIPRD	's Investigative Report focus	es on the TBPS investig	gation into SD's
death prior to the rea	ssignment of the file.		











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 _______ one of the Forensic Identification officers, which again would be consistent with either accident or criminal intervention.

Several officers, including , 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 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 led what little investigation took place.
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 , played no role in the further investigative work that
subsequently took place.

The deficiencies in the investigation led by 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.

, 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 and and , as
well as the OPP review, highlighted the deficiencies in the earlier investigation.
expressed concern that the original investigators,
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
He did not feel, however, that the failings in the original investigation were
attributable to racial bias.



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 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.

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.



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.

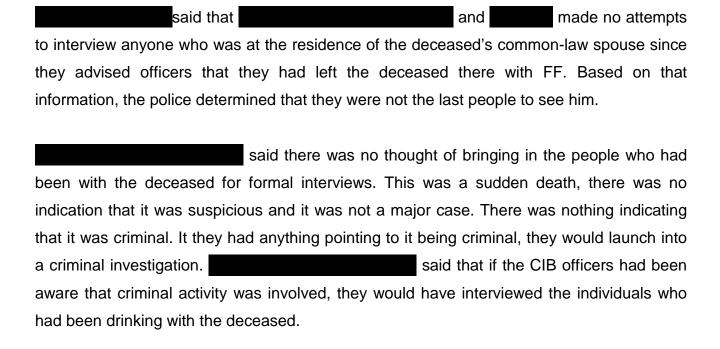
said that told the family that there was nothing to indicate that foul play was involved in the death of SD. If new information pointed to criminal activity, they would launch an investigation or look into it further. According to only said that rolling into the river was one of the possibilities. He 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.

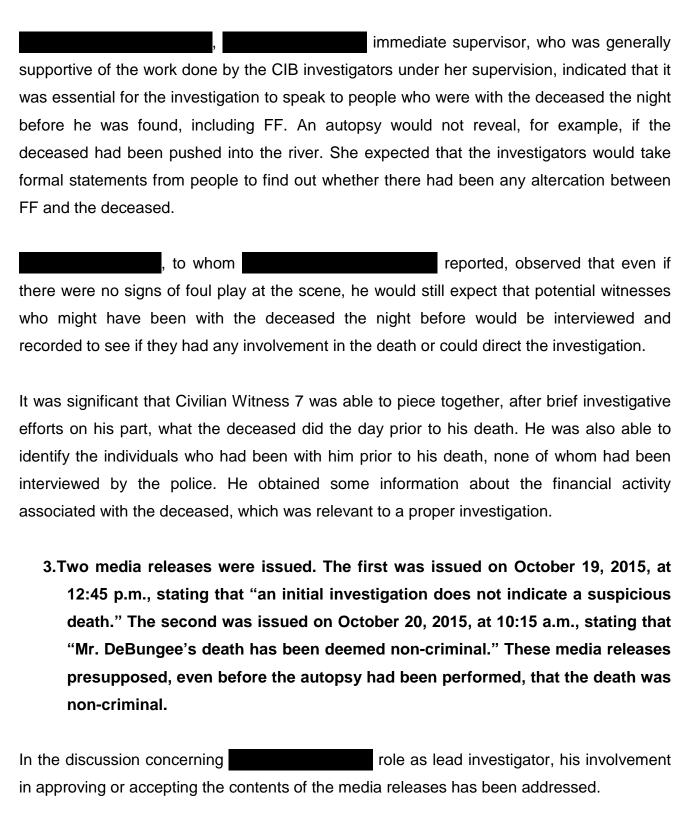


Such formal statements would likely have yielded evidence relevant to the investigation: for example, evidence pertaining to the use of the deceased's debit card post-death. This was an important avenue for further investigation, whether it was ultimately proven to be relevant to the cause of death. 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.



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.





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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 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:

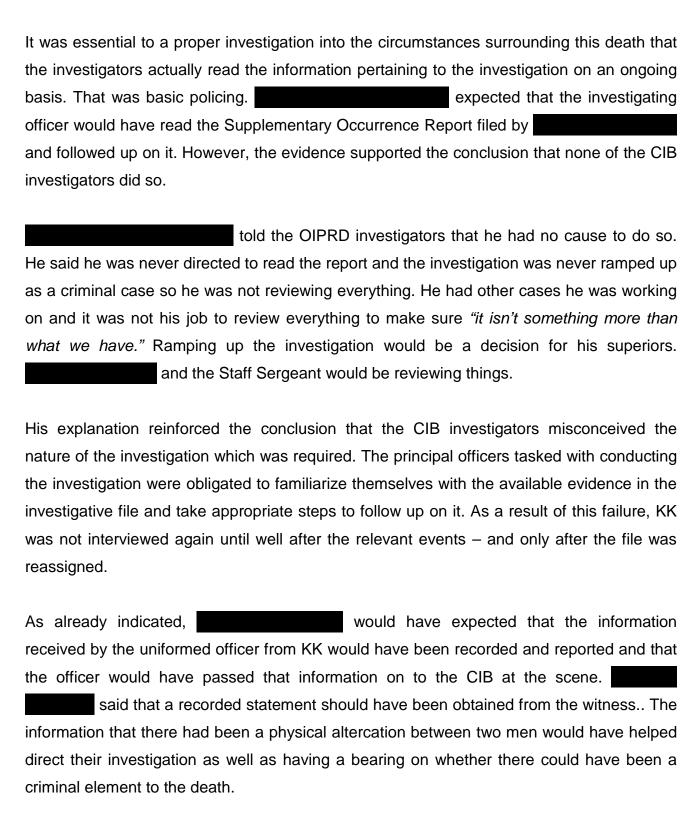
"That they were so quick to go to the media and say that no foul play was suspected and that there was no criminality. As an Investigator, and especially somebody that's experienced in death investigations, that just seemed like that was happening long before, you know, the police had time to interview 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.

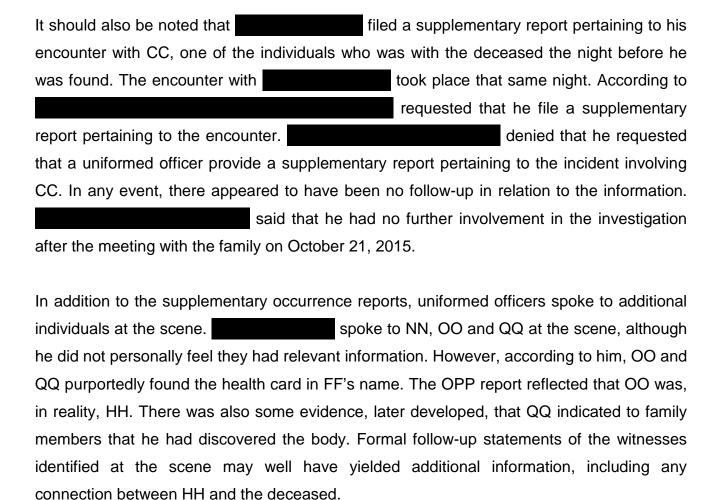


4. The CIB investigators, most importantly, did not review, on		
an ongoing basis, supplementary occurrence reports in the investigative file,		
and as a result, was unaware, for example, of the informal interview with KK		
conducted at the scene by an uniformed officer in which a witness described a		
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.		
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, 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. was 100 per cent		
confident that 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.		
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.		
said that the information was not passed on at the scene.		
was unaware of this information. 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 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.		









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.

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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.

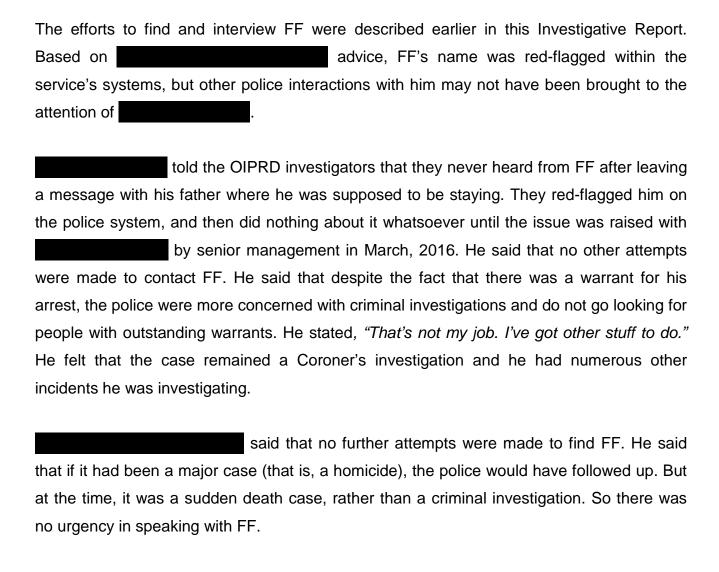
a member of the Forensic Identification Unit, acknowledged that no videos were taken at the scene. She felt that the Unit would only take videos at scenes they believed were homicides.

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.

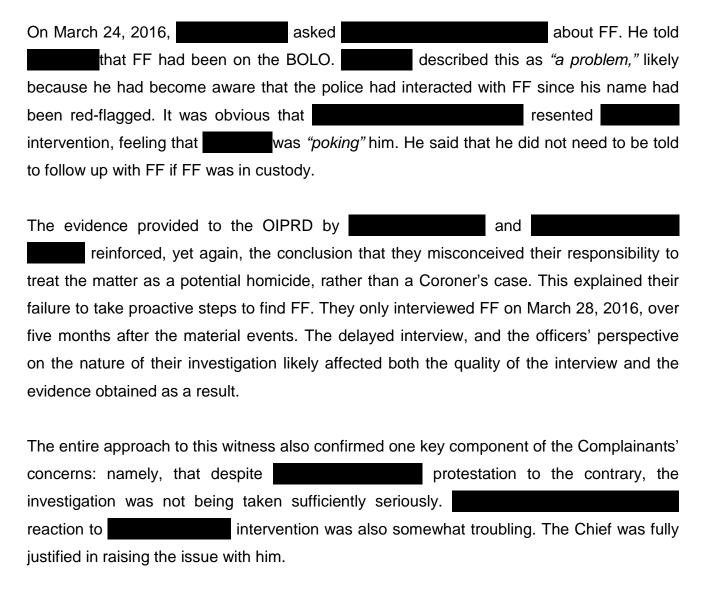
The evidence of the Forensic Identification Unit officers reinforced the conclusion that, for all intents and purposes, the CIB investigators treated the death as a non-suspicious death virtually from the outset. The Coroner's input did not relieve the CIB investigators of their responsibility to conduct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







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.

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. chose not to meet with Civilian Witness 7, the private
investigator and former homicide detective.
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 explained, at least in part, why
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 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, 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.

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10. The OPP found that _______ 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

It is also acknowledged that not every deficiency identified in the investigation led by 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.

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 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.

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

played a significant role in this inadequate investigation.

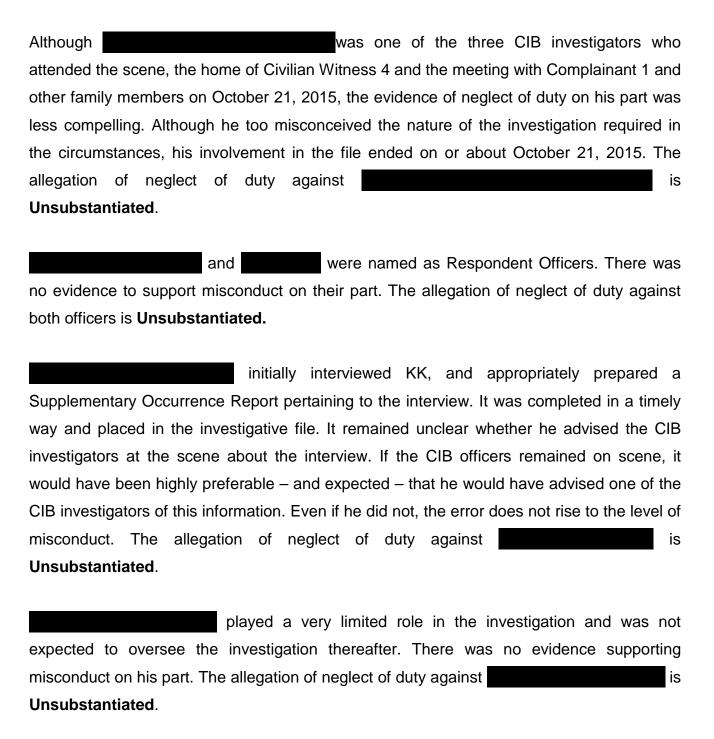
Although he bears less responsibility for it than

responsibilities, and was involved throughout, right up to and including the interview he and conducted with FF.

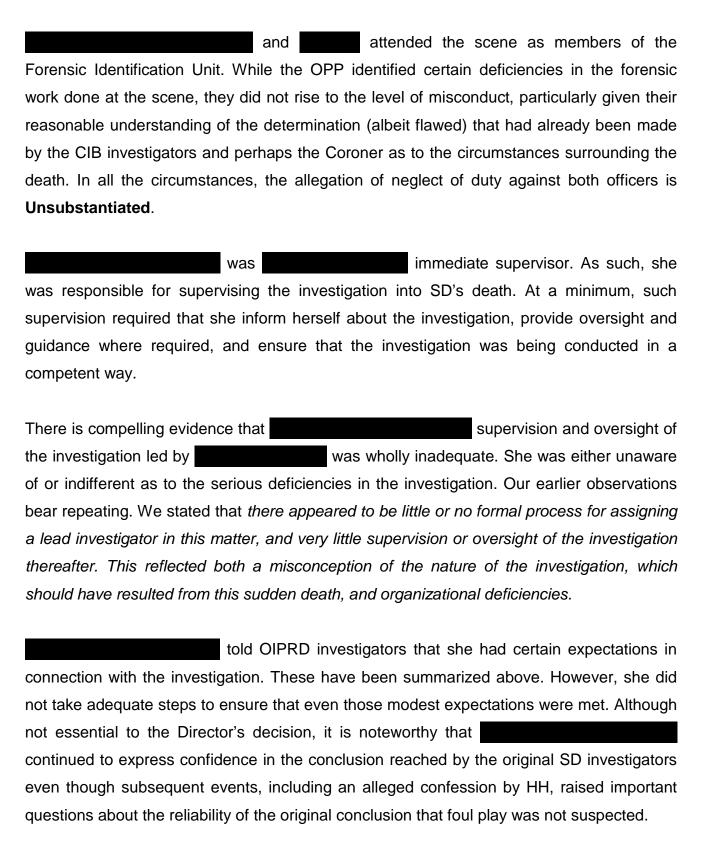
Therefore, upon review and analysis of all available information, the Director has determined that there is sufficient evidence to establish that misconduct occurred in this complaint. As a result, with respect to the allegation of neglect of duty, the conclusion is:

Substantiated against











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 <u>there is sufficient evidence</u> 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

, in turn, reported to ______. 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 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 and others believed that they do not engage in differential treatment based on race. It is also accepted that 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 and 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.

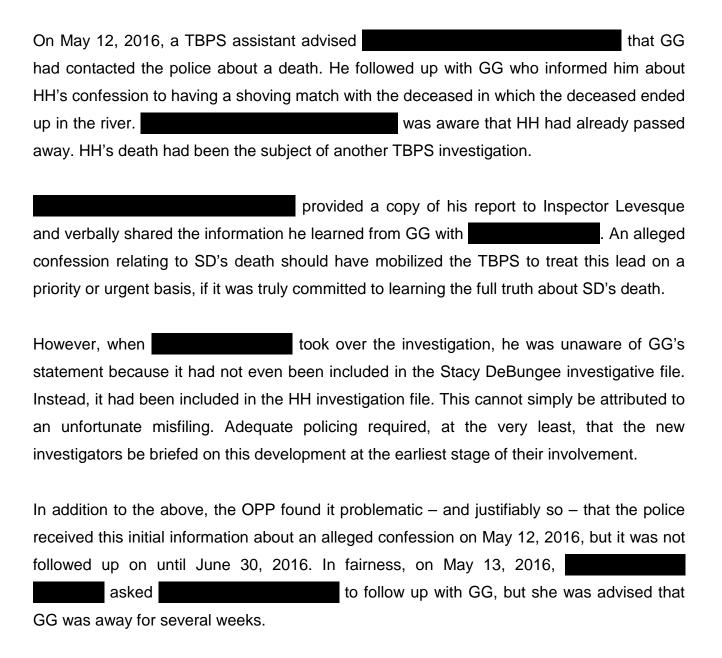
A finding of discreditable conduct is not dependent on an intention to discriminate, or even subjective awareness, at the time, that the conduct involves a failure to treat or protect persons equally without discrimination based on race and other enumerated grounds. The actions of the officer do not 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 O	ntario Human Rights Code, to recognize
the inherent dignity and worth of every person	and to provide for equal rights withou
discrimination. Persons, in this context, include tho	se whose deaths are being investigated
along with their families. It can reasonably be infe	erred that the investigation conducted by
and	failed to fulfill that public policy.
Therefore, upon review and analysis of all a	vailable information, the Director has
determined that there is sufficient evidence to es	tablish that misconduct occurred in this
complaint. As a result, with respect to the allegation	n of discreditable conduct, the conclusion
is: Substantiated against	and
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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.





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