FALCONERS
LLP

Findings of the OIPRD

Re: Thunder Bay Police Services' Investigation into the Death of Stacy DeBungee

Litigation with a conscience.

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The Criminal Investigation Bureau ("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. (pg. 104)

- [redacted] wrote in his notes at 10:45 a.m., on October 19, 2015, that he believed the death was non-suspicious in nature. The OPP concluded that there did not appear to be any basis for this conclusion at that stage, especially in light of the cause of death not having been identified yet and a witness at the scene indicating that he had seen two people in an altercation the night before.
  (pg. 106)

- 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 (pg. 107)

No formal statements were taken from any of the individuals who were with the deceased shortly before his death. These individuals should have been formally interviewed at the earliest opportunity. (pg. 107)

- [redacted] said there was no thought of bringing in the people who had been with the deceased for formal interviews. (pg. 108)

- 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. (pg. 119)

Two media releases were issued. The first was issued on October 19, 2015, at 12:45 p.m., stating that "an initial investigation does not indicate a suspicious death." The second was issued on October 20, 2015, at 10:15 a.m., stating that "Mr. DeBungee's death has been deemed non-criminal." These media releases presupposed, even before the autopsy had been performed, that the death was non-criminal. (pg. 109)

- The OPP concluded that there was no basis, at that stage, to determine that the death was non-criminal. A potential homicide should be treated as a serious criminal matter. The media releases undermined confidence in any criminal investigation which followed, which should have been foreseeable by [redacted] in light of the existing issues between TBPS and Indigenous people. The media releases also potentially undermined the willingness of witnesses to come forward. (pg. 110)

The CIB investigators, most importantly, [redacted] did not review, on an ongoing basis, supplementary occurrence reports in the investigative file, and as a result, was unaware, for example, of the informal interview with KK conducted at the scene by an uniformed officer in which a witness described a physical altercation between Indigenous men at the scene the night before the deceased's body was found. Formal interviews should have been conducted of KK and others informally interviewed by uniformed officers at the scene. (pg. 111)

- It was essential to a proper investigation into the circumstances surrounding this death that the investigators actually read the information pertaining to the investigation on an ongoing basis. That was basic policing…However, the evidence supported the conclusion that none of the CIB investigators did so. (pg. 112)

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. (pg. 114)

- The photographs taken did not focus on the body and the riverbank area. (pg. 114)
- In the interviews conducted with the OIPRD investigators, the TBPS investigators demonstrated how poorly they understood their responsibilities in this sudden death investigation. (pg. 106)
- 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. (pg. 114)

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. (pg. 115)

- [redacted] stated that they never heard from FF and that concluded their investigation. No further attempts were made to contact him. (pg. 67)

- The evidence provided to the OIPRD by [redacted] and [redacted] reinforced, yet again, the conclusion that they misconceived their responsibility to treat the matter as a potential homicide, rather than a Coroner's case. This explained their failure to take proactive steps to find FF. They only interviewed FF on March 28, 2016, over five months after the material events. (pg. 116)

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. (pg. 116)

- There appeared to be little or no formal process for how a lead investigator was assigned and very little supervision or oversight of the investigation thereafter. That reflected, among other things, a misconception of the nature of the sudden death investigation and organizational deficiencies. (pg. 102)

- At the time of the investigation, TBPS did not have a formal review process for ongoing death investigations. That raised obvious systemic issues. (pg. 122)

No broader canvas of the local businesses and area residences was conducted, standard fare for a potential homicide. (pg. 117)

- [redacted] indicated that he walked up and down looking for external cameras on buildings close to the scene. He did not see any and that was the extent of his efforts. In his experience, if he could not see an external camera, it meant that one did not exist. That approach could hardly be described as thorough. (pg. 117)

[redacted] chose not to meet with Civilian Witness 7, the private investigator and former homicide detective. [redacted] said that he was not going to speak to any private investigator about the case. (pg. 117)

- As Civilian Witness 7 observed, if a family believed that something untoward happened to their loved one, it is up to the police to take that seriously and investigate the matter. Unfortunately, [redacted] decision not to meet with the private investigator further contributed to the family's reasonably held belief that the matter was not being taken sufficiently seriously. (pg. 117)

Because of the premature determination that this was a non-suspicious death, no forensic examination was conducted on the exhibits. (pg. 118)

- 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. (pg. 118)

- 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. (pg. 94)

Systemic Racism

- **The evidence overwhelming [sic] supports the inference that [redacted] and [redacted] prematurely concluded that SD rolled into the river and drowned without any external intervention. It can also be reasonably inferred that this premature conclusion may have been drawn because the deceased was Indigenous. (pg. 123)**

- **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. (pg. 124)**

Seven Youth Inquest Began Two Weeks Earlier

It was also troubling that this inadequate investigation took place in the context of an ongoing coroner's Inquest into the Deaths of Seven First Nations Youths, most involving river-related deaths. As [redacted] acknowledged, one would have reasonably expected that investigators would be particularly vigilant in ensuring that the investigation of the sudden death of an Indigenous man found in the river was thorough and responsive to the community's concerns. Unfortunately, the opposite was true here. (pg. 118)

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