RECOMMENDED IN THE BROKEN TRUST REPORT OFFICE OF THE INDEPENDENT POLICE REVIEW DIRECTOR (OIPRD)

ADDITIONAL DEATH CASES WARRANTING FURTHER INVESTIGATION Prepared for The EXECUTIVE GOVERNANCE COMMITTEE (EGC)

Submitted by the Blended Investigative Team

Updated February 2022

Disclaimer:

Not all additional Thunder Bay Police Service sudden death cases that may warrant further investigation have been identified during the re-investigation process. Due to finite timelines and resources allocated to the process outlined in this report, cases provided here are not an exhaustive list.

INTRODUCTION

The Blended Investigation Team (BIT)[1] has engaged in a systematic process in order to meet the Broken Trust Reinvestigation Terms of Reference (TOR) expectation to, "Share with the Executive Governance Committee additional cases identified during the reinvestigation work that, in the view of the team lead, would warrant further investigation". The process outlined in this report is also in support of the OIPRD recommendation #3, "The multi-discipline investigative team should establish a protocol for determining whether other Thunder Bay Police Service (TBPS) sudden death investigations should be reinvestigated".

To effectively support the EGC in their decision-making process and next steps, the BIT engaged with experienced death investigators from a number of law enforcement services, forensic pathology, the coroner's system and legal counsel to arrive at ten additional cases that warrant further investigation into the manner of death and two additional cases for the Office of the Chief Coroner (OCC) consideration in public safety matters concerning vulnerable missing persons and fatal drug overdose.

The BIT worked with finite timelines and finite resources to arrive at the recommendations included in this report. Due to limited realities, this report does not include a review of TBPS RMS sudden death cases from calendar year 2021, nor is the BIT aware of cases in 2021 that should be brought to the EGC attention. The BIT asks that this report be reviewed as a **snapshot into the TBPS RMS** and investigative concerns documented in this report.

[1] TBPS members originally assigned to the Blended Investigative Team for the purpose of reinvestigating cases identified in the OIPRD Broken Trust report were not part of the process or work outlined in these additional cases report. For the purpose of this report, when "BIT" is listed it does not include any staff or sworn officers from the TBPS, nor their opinions.

ADDENDUM – JANUARY 2022

In late summer/early fall of 2021, it was brought to the EGC's attention that the identified additional cases were not shared with all members participating in the Broken Trust reinvestigation process.

To help ensure a fair, balanced, and focused process for review took place, the OCC provided direction on behalf of the EGC and a case review tool was sent out so all members had the opportunity to review case materials from the identified 17 sudden deaths (please see the Methodology section for a description of the BIT led TBPS RMS additional sudden death case identification process).

As a result of the addendum process four new cases were identified and added to this report, in turn making the total count for the EGC's consideration 14 additional sudden deaths of Indigenous peoples in Thunder Bay, for further police investigation, as well as a missing persons death and drug death investigation for Coroner review. The four new cases are: V.K. (deceased 2006), L.A. (deceased 2013), C.A. (deceased 2014) and N.F. (deceased 2019).

KEY FINDINGS and IDENTIFIED THEMES

The BIT had access to the TBPS Records Management System (RMS) at different points in time during 2020 and 2021, and in addition to identifying additional cases the BIT observed a number of thematic concerns for the EGC's consideration and in support of the final report writing, these concerns are:

Lack of Documentation / Incomplete Police Investigations

- Appears to be less than complete sudden death investigations and a lack in consistency, as well as accuracy in manner of death classifications.
- Appears to be a lack in thorough and complete sudden death cases, as well as a lack in background checks. No Major Case Management (MCM) on some complex death investigations.
- Appears to be a concerning number of sudden death investigations that remain open, manner of deaths unresolved, lack of medical documentation and cause of death in the TBPS RMS.

Lack in Coroner Involvement

- Appears there are cases in which coroners have not attended scenes nor ordered postmortem examinations to determine cause of death.
- Appears that coroners and investigators are making premature comments on no foul play and releasing scenes before a postmortem exam is complete in some suspicious death investigations.
- Appears that in some cases postmortem reports (with toxicology) do not appear to be forwarded to the TBPS by the OCC.

METHODOLOGY

A systematic process was established for the BIT to meet the EGC expectation in identifying additional sudden death cases that warrant further investigation and to comply with the OIPRD Recommendation #3, this process included:

- The TBPS RMS review process of sudden death cases mainly focused on calendar years 2010-2017, with a limited review of cases between 2018-2020 and 2000-2009.
    - The decision to start with 2010-2017 for the case review timeframe was to align this process with the OIPRD Broken Trust Report timeframe, and to include additional years in the RMS search when BIT timelines and resources permitted additional reviews.
- Analysts entered the TBPS RMS and completed an initial query based on search types for the timeframe of 2010-2017, as well OCC records for Indigenous deaths between 2003-2009, which were queried individually. These processes generated a total of 1,771 TBPS occurrences that were then reviewed by BIT members with TBPS RMS access.
    - 229 occurrences were identified and sent to experienced BIT sworn death investigators currently working with different law enforcement agencies.
    - Sworn officers consisted of male and female members, as well as Indigenous and non-Indigenous experienced homicide and sudden death investigators, including members from two First Nations Police Services.
- BIT death investigators reviewed cases of investigative concern and recommended 17 cases for further discussion with experienced death investigators in forensic pathology, the coroner's system and criminal law prosecutions for their opinions and collective decisions regarding if the case should be recommended to the EGC for further consideration.[2]

[2] BIT police reports and medical reports on additional cases presented in this document for the EGC consideration are available, if needed please contact Ken Leppert, Blended Investigative Team Lead at Ken.Leppert@ontario.ca.

- Case conferences took place with law enforcement, forensic pathology, a coroner and criminal law counsel, in which BIT police reports on the 17 additional cases, original coroner reports, postmortem reports, toxicology reports, other Centre Forensic Sciences (CFS) reports, person(s) of interest and background checks were discussed in detail.
    - As a result of collective efforts in these case conferences 10 cases were identified and confirmed that, in the opinions of the BIT lead and experienced death investigators, warrant further police led investigations.
        - ❖ As noted in the addendum paragraph (page 3), four new sudden death cases were identified and added to this report, in turn making the total count for the EGC's consideration 14 sudden death cases.
    - An additional two cases were included in this report for consideration of a coroner led review as it was decided these cases may support public safety interests and further investigative follow-up.

ADDITIONAL CASE #1

L.M. (deceased 2010)

Reasons that Warrant Further Investigation

The decedent and family deserve to have the manner of death properly classified. A full review of all existing documents including all police reports, scene and autopsy photographs, officer notes, medical reports should be conducted to the standards of Ontario MCM. An independent blended investigative team, that includes Indigenous representation, under the direction of a Major Case Manager, in consultation with an independent Coroner and Pathologist is an option to be considered. Further criminal investigation of this incident will be difficult now that the suspect is deceased, however as stated above proper manner of death classification is warranted. If evidence of criminality is uncovered, it should be investigated to the standards of Ontario MCM.

The TBPS categorized a male “suspect” in this incident. A polygraph examination never occurred. The decedent died as a result of a serious head injury that she reported directly to police officers was caused by the suspect. He has never been eliminated as a suspect. This investigation was left incomplete.

Case Summary and Investigative Shortcoming

This is a 2010 death of 46-year-old indigenous female who died in the Thunder Bay Hospital. TBPS were dispatched to the Thunder Bay Shelter House in relation to a female who had been pushed and hit her head. Uniform officers spoke with the decedent who provided her personal information. She was holding the back of her head on the right side and said it was sore.

She indicated to officers that she had been pushed by a male whom she identified as the suspect at the Beer Store and that she hit her head against the wall, near the back alley. She also provided similar versions to multiple witnesses.

EMS personnel noted that she had a slight bump on the back of her head on the right side. She was transported to hospital for precautionary reasons.

The decedent was discharged from hospital within an hour of arriving by ambulance. She returned to the Shelter House. She was observed by staff, continuing to rub the back of her head. Several attempts were made to wake her. An ambulance was requested when she appeared unconscious. She was admitted into the Intensive Care Unit (ICU) where she died two days later.

The surgeon caring for the decedent while in hospital advised that there was severe damage to the decedent's brain. The doctor believed she had fallen down a flight of stairs. There was evidence consistent with an assault, yet it did not appear that information was communicated to medical personnel and an assumption was made otherwise.

TBPS gathered video surveillance, but none assisted in showing the decedent in public. The video surveillance from the Shelter House proved to be helpful in creating a timeline of her coming and going from there. A limited canvass was conducted. Several witness statements were also secured. MCM does not appear to have been applied.

The Coroner directed that because of the suspicious nature of this death, the post-mortem examination would occur in Toronto. He also requested TBPS Forensic Identification Unit (FIU) officers attend the autopsy in person. The autopsy location was changed to Thunder Bay. The reported cause of death was "anoxia of the brain, secondary to subdural hematoma, secondary to blunt head trauma."

Several rumors circulated about the decedent falling and injuring herself. However, no direct evidence of a fall was reported. The decedent, throughout her disclosures to the initial uniform officers and three civilian witnesses was generally consistent with her information about being assaulted and injured by the suspect. She was never afforded the opportunity to provide a detailed account in a formal statement to the police.

The suspect was interviewed by investigators on video, under caution. Several inconsistencies and areas of deception were noted, as well as information that corroborated the decedent's allegations. A background check of the suspect was never reported. The suspect had convictions for violent offences and was a victim of a homicide himself in 2015.

ADDITIONAL CASE #2

L.O. (deceased 2010)

Reasons that Warrant Further Investigation

The decedent and family deserve to have the manner of death properly classified. A full review of all existing documents including all police reports, scene and autopsy photographs, officer notes, medical reports should be conducted to the standards of Ontario's MCM. An independent blended investigative team, that includes Indigenous representation, under the direction of a Major Case Manager, in consultation with an independent Coroner and Pathologist is an option to be considered.

Further criminal investigation of this incident relating to the boyfriend will be difficult now that he is deceased, however as stated above proper manner of death classification is warranted. If evidence of criminality is uncovered, it should be investigated to the standards of Ontario's MCM.

Case Summary and Investigative Shortcoming

This is the 2010 death of a 42-year-old Indigenous female found deceased in a hotel room in Thunder Bay. Suspicious circumstances surround how the decedent's daughter located her dead while alone in the company of her intimate partner in the hotel room bathroom. There was some indication from the scene that she had hung herself.

There was conflicting information about the condition of the body, however, the EMS attendant believed rigor was in its initial stages, suggesting the body had been deceased for a period of time. A TBPS forensic identification officer described the circumstances as unusual and notified the Criminal Investigation Branch (CIB). Coroner was requested but did not attend scene.

Further suspicious injuries (including to the neck and face) were noted at the time of the initial autopsy. After requesting additional interviews be conducted, the Coroner eventually decided upon a cause of death of "asphyxiation from a ligature."

MCM structure was not applied. No case conference with medical experts and investigators was undertaken. Opportunities to interview witnesses and seize video from within the hotel were missed.

Daughter reported a history of physical abuse and control in her mother's relationship, from the boyfriend. No background check on boyfriend was reported to have been completed. The boyfriend is the last person to have been with Christine Gliddy (OIPRD reinvestigation) prior to her suspicious death in March of 2016. That death has been reclassified to a manner of undetermined. He had previous convictions for multiple assaults, uttering threats, and was reported to have harassed four other women while living at the Shelter House in Thunder Bay around the time of Christine Gliddy's death. He was also on the DNA offender databank. He was never interrogated under caution or offered the opportunity of a polygraph examination in this investigation. The boyfriend died in 2017.

ADDITIONAL CASE #3

A.M. (deceased 2010)

BIT Reasons that Warrant Further Investigation

All Ontario police services are under a legal obligation to immediately notify the Special Investigations Unit (SIU) of incidents of serious injury, allegations of sexual assault, or death involving their officers. The SIU and TBPS were consulted and at the time of this additional cases report to the EGC, no records indicate a notification to the SIU in this matter. This case was turned over to the SIU for further investigation and requires no further action by Broken Trust.

Update from the SIU Director's Public Report – Case #21-OCD-228

Public Reference Link: https://siu.on.ca/en/directors_report_details.php?drid=1655

Public Report Date: November 17, 2021

Electronically approved by Joseph Martino, Director, SIU

> "The Complainant died in Thunder Bay on April 1, 2010 following an interaction with TBPS officers. His death was investigated at the time by the TBPS, which found that the Complainant died of a medical condition unrelated to any conduct on the part of TBPS officers. The incident was recently reported to the SIU following the report by the OIPRD – Broken Trust – into concerns regarding the investigation of the deaths of Indigenous persons by the TBPS.
>
> The SIU opened a file and commenced an investigation, identifying SO #1 and SO #2 as subject officials. The investigation has now concluded. On my assessment of the evidence, there are no reasonable grounds to believe that either subject official committed a criminal offence in connection with the Complainant's death.
>
> The offences that arise for consideration are *failure to provide the necessaries of life* and *criminal negligence causing death* contrary to sections 215 and 220 of

the *Criminal Code*, respectively. The former is premised, in part, on conduct that amounts to a marked departure from the level of care that a reasonable person would have observed in the circumstances. The latter is reserved for more serious cases of neglect that demonstrate a wanton or reckless disregard for the lives or safety of other persons. It is not made unless, *inter alia*, the impugned behaviour constitutes a marked and substantial departure from a reasonable level of care. In the instant case, the issue is whether there was any want of care on the part of either, or both, of the subject officials that caused or contributed to the Complainant's death and/or was sufficiently egregious to attract criminal sanction. In my view, there was not.

There was nothing in the evidence gathered by the SIU to suggest that SO #1 and/or SO #2 were unlawfully placed at any point in their dealings with the Complainant. The officers were acting in the course of their duties when, at the request of the apartment's owner, they escorted the Complainant from the premises.

Nor is there evidence sufficient to reasonably establish that either officer failed in their duty of care towards the Complainant. They had no idea that the Complainant suffered from a heart condition that would soon result in cardiac arrest and, tragically, death, and therefore were without cause to believe that he required immediate medical attention. The officers were aware that the Complainant was very inebriated. However, his intoxication was not such that he was unable to take care of himself; he had gotten dressed when asked to do so by the officers, and was able to walk with the officers onto the sidewalk outside the Royal Edward Arms and ask for help when he collapsed onto the ground, by which time the officers had left the scene. On this record, I am unable to reasonably conclude that either of the subject officials failed to comport themselves with due care and regard for the Complainant's health and well-being.

> In the result, as there are no reasonable grounds to believe that the subject officials transgressed the limits of care prescribed by the criminal law in their engagement with the Complainant, there are no grounds for proceeding with criminal charges in this case. The file is closed." (SIU Case #21-OCD-228)

BIT Case Summary and Investigative Shortcoming

This is the 2010 death of a 50-year-old Indigenous male that died on a sidewalk in Thunder Bay. In the early morning hours, TBPS were called to a report of an assault at an apartment building. Two uniform officers attended and spoke with a female complainant who advised that there were several unwanted individuals in her apartment that she was afraid of and wanted them removed.

The uniform officers attended at the complainant's apartment and were met by the decedent. He was shirtless and his pants were undone. He had a large visible scar on his chest from heart surgery. Another male who was never identified by officers, was sober and sleeping on a mattress on the floor. Officers instructed both males to leave the apartment. TBPS described the decedent to be "extremely intoxicated." The decedent put on a button-down shirt and tried to leave by the rear fire escape stairwell.

Uniform officers directed the decedent to come with them in the elevator. The officers escorted him from the apartment, down the elevator and out the front entrance of the building, away from where they believed the complainant to be. Officers then tried to locate the complainant but were unsuccessful. They cleared the scene leaving the decedent alone, outside of the apartment building. They classified the incident as non-reportable.

The temperature at the time was reported to be -3.5 degrees Celsius (dew point temp). Civilian witnesses reported observing the decedent in front of the apartment building, first standing and then falling to the sidewalk. He was unable to get up.

Video surveillance from Eye in the Street confirmed the initial TBPS cruiser departed the area. Less than forty-five seconds later civilian witnesses could be seen attending to the decedent, who was now on the sidewalk in front of the entrance to the same apartment. A separate TBPS cruiser and two uniform patrol officers arrived on scene approximately three minutes later.

The second pair of TBPS officers were in the area for an unrelated reason. They had heard the previous call over the police radio. They stopped as the decedent was clearly in need of assistance. They described the decedent as wearing a nylon jacket, blue jeans with the fly open. The decedent was having trouble breathing and he was moaning. An ambulance was requested.

The decedent stopped breathing as ambulance arrived. CPR was initiated. Fire Department personnel and EMS carried the male to the back of the ambulance and continued CPR. He was pronounced dead while in the ambulance.

The original complainant spoke to officers and indicated that the male had been in her apartment during the day but did not know his name. He had been complaining of feeling unwell, headache and possibly vomiting blood.

The scene was not secured. The death was not investigated further by the TBPS. The coroner did not attend the scene. A postmortem was ordered. The medical records have been archived at the time of this report. OCC records indicate the cause of death to be cardiovascular myocardial infarction with the manner classified as natural causes.

In discussing this case with the IRC, medical expert advised cold weather can cause blood vessels and arteries to constrict, thus making the heart work harder to pump oxygen-rich blood throughout the body. The risk of heart attacks, angina and other heart-related problems increases with very low temperatures.

ADDITIONAL CASE #4

D.F. (deceased 2012)

Reasons that Warrant Further Investigation

The actions of the two persons of interest need to be investigated according to Ontario MCM standards. An independent blended investigative team, that includes Indigenous representation, under the direction of a Major Case Manager, in consultation with an independent Coroner and Pathologist is an option to be considered. If evidence of criminality is uncovered, it should be investigated to the standards of Ontario's MCM.

There was no indication that the DU5 forms/questionnaire was completed by investigators with the parents. Several discrepancies in both parents account of events leading up to the death.

Historical injuries confirmed at the PM included a broken arm and both legs, separate from any potential cause of death. Serious concerns for physical child abuse was flagged by the Pathologist. No police follow up until directed by coroner. First formal interviews by TBPS occur seventeen days after the death.

Oxycodone, cocaine, morphine and other drugs being used by parents. Traces of cocaine confirmed in decedent's urine.

The father was caught in several lies when questioned by the Indigenous child welfare worker. He admitted to injuring the baby's arm in bed and providing him no treatment for the injury except a sling; admitted to partying and cocaine use by both parents the night before the baby's death and all four sleeping in the same bed on the night of the death. All this information, if it had been collected properly, should have led to a criminal negligence causing death investigation.

Cause and manner of death was undetermined. A plan was laid out for a case conference between medical personnel, police, Indigenous child welfare staff and a

local Crown Attorney. There is no further investigation or consultation reported. The investigation is left incomplete.

Case Summary and Investigative Shortcoming

This is the 2012 death of an Indigenous 2-month-old male found unresponsive in an apartment in Thunder Bay. The decedent was pronounced dead shortly after arriving at hospital. Early reports of no concerns of foul play or suspicion. Parents indicated the decedent was sleeping separately and alone in the home when found.

No canvass. No MCM. No interviews were conducted throughout this investigation with persons associated to the involved persons, such as family or friends. No forensic interviews/interrogation/polygraph of either parent/caregiver. TBPS did conduct background work in this investigation and were aware that both parents had concerning violent histories that included allegations of abuse on their 14-month-old son who lived in the same home.

Scene released on day of death and prior to PM. RMS shows a clearing status as “Hist – Not Cleared (continuing)” as of the initial incident date. It is noteworthy that the clearance status remains ongoing when there is no further investigation being conducted. The last report on RMS is dated February 2014 and involved the destruction of all exhibits that had been seized. The clearance should be updated to show Complete – Solved or Unsolved.

ADDITIONAL CASE #5

G.C. (deceased 2013)

Reasons that Warrant Further Investigation

The decedent and family deserve to have the manner of death properly classified. A full review of all existing documents including all police reports, scene and autopsy photographs, officer notes, medical reports should be conducted to the standards of Ontario's MCM. An independent blended investigative team, that includes Indigenous representation, under the direction of a Major Case Manager, in consultation with an independent Coroner and Pathologist is an option to be considered. If evidence of criminality is uncovered, it should be investigated to the standards of Ontario's MCM.

Medical evidence may be available through the Thunder Bay hospital to support the cause of death. EMS transported the decedent to hospital where it was confirmed he had a significant brain bleed, hematoma on both sides of his head that had caused brain damage that was inoperable.

The actions of the three suspects related to this incident need to be further investigated. All three suspects were located and interviewed by TBPS Detectives. However, none of these interviews were under a police caution or captured on audio or video recording. Two of the three provided inaccurate information to police and the third denied being at the scene. All three suspects should be interviewed/interrogated under police caution. A full review of available forensic evidence is also warranted. No background information is reported by TBPS. All three suspects have violent backgrounds and one is identified as a gang member.

Case Summary and Investigative Shortcoming

This is the 2013 death of a 45-year-old Indigenous male. TBPS received two 911 calls just before 1:00am reporting an incident in Kamview Park in Thunder Bay. The first call described an intoxicated male falling and others trying to help him up. The second call described a fight in the middle of the road where a group of males were, "kicking the daylights out of a guy."

Uniform officers arrived at scene within two minutes of the call and located an injured male on the ground. Three other males were standing around the injured male who had blood around his mouth, blood on the right side of his head, in his hair and he was unconscious. All three males were identified by police. One of them had blood on his sandal. The footwear was seized. They all denied any altercation with the injured male. Blood and clumps of hair located and seized in two different locations within the scene.

Witnesses who called 911 were interviewed later the same day. Varying accounts included the decedent falling and hitting his head while being kicked by the three males. Two of the witnesses confirmed that the males who assaulted the decedent remained at the scene until the police arrived and spoke to them.

The decedent died in hospital two days after the initial incident. The cause of death was listed as blunt force injuries to the head. The Coroner's Investigation Statement indicated that upon discussions with police about this investigation it was decided that an autopsy was not required.

No analysis was ever completed on the blood from the sandals. All property seized in this investigation has since been disposed of by the TBPS. Video surveillance of the park area and areas where the suspects reported walking prior to arriving at the park were never secured.

ADDITIONAL CASE #6

N.M. (deceased 2013)

Reasons that Warrant Further Investigation

The decedent and family deserve to have the manner of death properly classified. A full review of all existing documents including all police reports, scene and autopsy photographs, officer notes, medical reports should be conducted to the standards of Ontario's MCM. An independent blended investigative team, that includes Indigenous representation, under the direction of a Major Case Manager, in consultation with an independent Coroner and Pathologist is an option to be considered. If evidence of criminality is uncovered, it should be investigated to the standards of Ontario's MCM.

There was no post-mortem examination ordered by the coroner on the sudden death of this 22-year-old woman that had several inconsistencies from witnesses at the scene. No toxicology reports are indicated by TBPS reports. There is a coroner's report on file that described the injuries sustained to the decedent as "catastrophic".

Investigators, including FIU officers, never had discussions with the coroner about returning to the scene to photograph it or conduct measurements of the stairwell that could have further assisted the coroner in his investigation of the death.

Based on the reported darkness in the stairwell at the time that the decedent fell down the stairs, her cousin would not have been able to see a push from one of the males behind the decedent. No motives were discussed in the witness statements or considered in this investigation. The two males involved have significant criminal records for violence. The second male died from an apparent drug overdose in 2019.

Case Summary and Investigative Shortcoming

This is a 2013 death investigation of a 22-year-old Indigenous woman that occurred when she fell down a set of stairs in the early-morning hours at a residence. She died one day later in hospital.

Investigators interviewed the two ambulance attendants that went to the scene and cared for the decedent and transported her to hospital. They separately described the decedent to be unconscious and bleeding badly around her head area. The stairwell was described as a steep narrow set of wooden stairs.

A female cousin of the decedent was interviewed by investigators and explained that the women spent the day together running errands, then the evening together drinking vodka before going to a bar around midnight and drinking there until it closed. She told investigators that she and the decedent left the bar with two males and went back to an apartment with them for more drinking.

When it was time to leave, the cousin reported that the decedent was first to the top of the stairs, followed by the two males and her at the back. The stairwell area was described as very dark and the cousin could only hear the decedent fall. She did not describe any fighting or arguing amongst the four of them at the apartment. The cousin did report that she believed the male directly behind the decedent had called 911, but then when the ambulance did not come, he would not tell her if 911 was called and would not let her see his phone to confirm the call. The cousin had to use another phone to call 911.

Further suspicious behavior continued with the males when investigators called the second male to discuss the incident and he denied being there and said someone else had his phone that night. Investigators did not interview that male until three weeks after the incident and he provided several inconsistencies and discrepancies from the cousin’s version of events. The male was interviewed in the Thunder Bay District Jail.

The male directly behind the decedent on the way down the dark stairwell agreed to speak to detectives the day after it was reported, but no statement was provided.

The mother of this decedent questioned investigators in 2015 about a letter she had received from the coroner and about the police investigation into the death. No further follow up was reported with the mother to answer her questions.

ADDITIONAL CASE #7

R.M. (deceased 2015)

Reasons that Warrant Further Investigation

The case needs to be investigated according to Ontario MCM standards. An independent blended investigative team, that includes Indigenous representation, under the direction of a Major Case Manager, in consultation with an independent Coroner and Pathologist is an option to be considered. The decedent and family deserve to have the manner of death properly classified. If evidence of criminality is uncovered, it should be investigated to the standards of Ontario's MCM.

The Seven Youth Inquest was set to begin within a month of this incident. A second Indigenous male, Stacy DeBungee was found face down in the McIntyre River shortly after this death. Further in July 2016 Clayton Mawakeesic was also found dead in the McIntrye River and the victim of manslaughter. There was no RMS reported linking or comparison of the three cases (R.M., Stacy DeBungee and Clayton Mawakeesic) regardless of these cases occurring within a 10-month period of time. TBPS were aware of public concerns in relation to water death investigations.

In January of 2019, TBPS received information through the family, that an identified suspect had pushed the decedent into the river, killing him. The suspect had a remarkably violent past which included having been charged with murder previously in relation to a violent attack on another Indigenous male found in a park in Thunder Bay. Family identified the direct source of the information and advised TBPS that the source was unwilling to share the information further. Further criminal investigation of this incident will be difficult now that the suspect is deceased.

Case Summary and Investigative Shortcomings

This is a 2015 death of a 50-year-old Indigenous male found face-down in the Kaministiquia River in Thunder Bay. No tarp was used to preserve any physical

evidence that may have come off the body when removed from the river. The witness who initially found the body was never interviewed.

A post-mortem examination was completed. The cause of death was consistent with drowning. The manner of death was later ruled accidental by the Coroner. At 4:00pm on the same date, the scene was released as the investigation had been ruled non-suspicious and no foul play suspected.

No evidence searches. No canvass. No video seized. There was no reported consultation with a CIB supervisor in relation to releasing the scene. No timeline. No MCM.

The direct source was interviewed in February 2020 by a uniform officer from another police service at the request of TBPS. A six-question written statement was taken, in which the individual denied knowledge. No effort was made to locate and interview the suspect directly by TBPS. The suspect was murdered in 2020.

There was no reported family update about the information provided to TBPS.
This death investigation was cleared on RMS as Complete – Solved (non-criminal) three days after the decedent's body was located in 2015. Investigation concluded with little if any knowledge of where the decedent had been and what he had been doing prior to entering the river.

ADDITIONAL CASE #8

Mi.M. (deceased 2016)

Reasons that Warrant Further Investigation

The actions of the suspect need to be investigated according to Ontario's MCM standards. An independent blended investigative team, that includes Indigenous representation, under the direction of a Major Case Manager, in consultation with an independent Coroner and Pathologist is an option to be considered. If evidence of criminality is uncovered, it should be investigated to the standards of Ontario's MCM.

The suspect has a lengthy history of violent offences, including weapons and domestic related occurrences where she is reported as the aggressor. It does not appear that she was the subject of a forensic interview/interrogation, polygraph examination or other investigative techniques.

The pathology report was supported through a peer review. Coroner's final report showed the means (manner) of death as Homicide. How the fatal chest wound was acquired remains under investigation. Although it is possible that this was self-inflicted, this man did not have a history of depression or suicidality. The other injuries argue as well, that he may have been defending himself. On balance of probabilities, this was homicide.

This case was reported and managed separate from TBPS RMS as a TBPS criminal investigation. As a result, our review has been limited to the final TBPS RMS report, Pathology Report, CFS Reports (Toxicology, Biology and Chemistry) and Coroners Report. Further investigation will require full access to all TBPS records related to this investigation. TBPS have confirmed this is not considered an unsolved homicide or an active investigation.

Case Summary and Investigative Shortcomings

This is the 2016 death of an Indigenous male found deceased in his apartment in Thunder Bay. TBPS received a 911 call from a female partner of a male reported to have stabbed himself in the neck. EMS located the decedent on the back landing of his third story apartment lying on his back in a pool of blood.

A single stab wound was found on the right clavicle at the edge of the sternum. The knife entered the body in a downward direction and punctured the top of the lung. A t-shirt worn at the time was not punctured by the knife. Knife and hairs belonging to an unidentified female found underneath the decedent's body. Mixed DNA sample from the decedent and the same unidentified female found from a blood swab taken from the kitchen sink. The CFS has never received a known comparison sample for the suspect who lived in the apartment with the decedent.

The TBPS report indicates - Treated as suspicious. MCM was engaged. Ontario Domestic Violence Death Review Committee consulted. A canvass of the building did not reveal an argument or struggle in the area of where the death had occurred. OPP Blood Spatter Expert examined scene.

The domestic partner (suspect) was interviewed under caution by the TBPS in which she stated a long history of domestic assaults from the decedent against her. The decedent and suspect had been at a bar where he had assaulted her. The decedent could turn violent when he drank and had caused her physical harm in the past. He was facing charges of domestic assault against her at the time of death. He had also accused her of cheating on him and controlled her social media by having her password. Having been assaulted by the decedent earlier that evening, the suspect had attended her sister's apartment that was located below the decedent's apartment and in the same building. The suspect could hear footsteps from the decedent's apartment. When they stopped, she believed he had left, and it was safe for her to return home. When she did, she found him stabbed and on the floor. The RMS report reads as if the TBPS accepted her statement as truthful.

The decedent had a violent history, including an incident where he pulled a knife on police. A postmortem examination reported several recent injuries. The Pathologist went on to report, “additional information from the Thunder Bay Police indicate that the deceased and his common-law had been heard arguing at about 1:00am in front of their apartment on street. They had a history of domestic arguments. The deceased was found on the balcony of his third-floor apartment.”

The knife was not examined by the original pathologist, however the police report indicated that the knife was intact. The original pathologist noted that in his medical experience suicidal stab wounds to the chest are much less common than homicidal wounds (anecdotal information).

Cause of death ruled as exsanguination due to transection of the right internal mammary artery due to a stab wound to the chest. The coroner’s report indicated the common law wife called 911 and stated that the decedent had stabbed himself and was bleeding. Police reports were not forwarded to the coroner at the time of his report.

Autopsy revealed a stab wound to the right upper chest with transection of the internal mammary artery and vein, puncture of the right lung and hemothorax. There were also abrasions of the left arm, right forearm and left ankle, contusions of the right forearm, right hand and chest, and two cuts to the left thumb. Toxicology revealed an elevated ethanol level.

There was a case conference with the medical experts and TBPS investigators. TBPS RMS report reads as follows, “It was clear during this meeting that the Forensic autopsy didn't offer any clear evidence that this wound could have been caused by another person. The wound could have been self-induced.”

TBPS RMS also reported, “That the suspect did not have any injuries to support a significant struggle. There is limited historical evidence that the decedent caused self-harm to himself with knives. The wounds on the left hand could not be determined to be

‘defensive’ in nature as there may be other explanations. Thunder Bay Police have experience with suicides/self-harm where victims were stabbed in the chest. The Coroner’s report classified this as a Homicide on the basis of probabilities not evidentiary finding as their classification falls under different guidelines/ balance of probability and not police evidence. No further action at this time”.

The BIT does not support the TBPS conclusions in this investigation as listed above.

ADDITIONAL CASE #9

J.M. (deceased 2018)

Reasons that Warrant Further Investigation

A full review of all existing documents including all police reports, scene and autopsy photographs, officer notes, medical reports should be conducted to the standards of Ontario's MCM. An independent blended investigative team, that includes Indigenous representation, under the direction of a Major Case Manager, in consultation with an independent Coroner and Pathologist is an option to be considered. If evidence of criminality is uncovered, it should be investigated to the standards of Ontario's MCM.

Incomplete investigation of a sudden death involving a domestic partner. Foul play has not been ruled out. Post-mortem examination confirmed the cause of death to be hanging.

Common law partner had been recently released from a federal penitentiary after serving a seven-year sentence for violent convictions that included a female victim and had previously been charged with choking another female victim and a separate violent sexual assault. No forensic interview or investigation to eliminate the common law partner's involvement in this death.

It was shown in reviewing other cases that the common law partner used his large stature as a means of intimidation and physical violence against women. Police reports describe him as a 6'7" and 215+ pound male.

Limited police investigation conducted (e.g., no canvass, no MCM, and no background checks). Additional investigation is warranted in this matter. There are no reports in the RMS of any meeting of the TBPS Sudden Death Review Committee in relation to this case (as per TBPS Sudden Death policy direction).

Case Summary and Investigative Shortcomings

This is the 2018 sudden death of an Indigenous female reported as a suicide by hanging. The decedent was found by first responders, laying on a bedroom floor with a rope around her neck. Her common law partner was the only person in the bedroom with the decedent at the time of death. His shirt was torn, and he had visible signs of recent injuries. His account of events leading up to the death are inconsistent.

The decedent's daughter was present in the apartment at the time and reported periods of loud physical and verbal altercations followed by a period of silence. The intoxicated common law partner who had been alone with the decedent then yelled for assistance that she had hung herself. A large hole was noted in the bedroom drywall. TBPS uniform officers reported no reasonable point of suspension observed within the bedroom. A post-mortem exam was completed in Toronto.

Initially this case was looked at as a criminal offence as TBPS wrote Criminal Code judicial authorization citing aggravated assault in the early stages of this investigation. There is no report to indicate why further criminal investigation was not pursued.

ADDITIONAL CASE #10

Me.M. (deceased 2018)

Reasons that Warrant Further Investigation

The actions of the two suspects (boyfriend and his friend) need to be investigated according to Ontario MCM standards. An independent blended investigative team, that includes Indigenous representation, under the direction of a Major Case Manager, in consultation with an independent Coroner and Pathologist is an option to be considered. If evidence of criminality is uncovered, it should be investigated to the standards of Ontario's MCM.

All three individuals present inside the apartment at the time of death were interviewed on video. None of them were questioned about the physical altercation the day before. The boyfriend and male friend both misled police by reporting that the decedent used cocaine and shot up prior to the death. Final toxicology results showed no cocaine or other illicit drugs detected. It is concerning that this may have been an attempt to cause investigators to believe the death was an overdose.

Neither the boyfriend nor his friend was the subject of a forensic interview, polygraph examination or further investigation to prove or eliminate their involvement. There are no reports in the RMS of any meeting of the TBPS Sudden Death Review Committee in relation to this case (as per TBPS Sudden Death policy direction).

Case Summary and Investigative Shortcomings

This is a 2018 death of a 34-year-old Indigenous female found vital signs absent (VSA) in an apartment in Thunder Bay. When police arrived at the scene, there were three others in the apartment, (1) the female tenant of the apartment, who is also the mother of the deceased's boyfriend, (2) deceased's boyfriend, and (3) his male friend. The decedent was VSA on a mattress in the living room.

The boyfriend was associated to two of the OIPRD Broken Trust Re-Investigations, the death of Sarah Moonias and the death of Christine Gliddy. Furthermore, he has an extensive and violent police history including previous convictions for domestic assault.

As well, the male friend was charged in a 2014 murder of an Indigenous male in Thunder Bay. He too, has an extensive and violent police history with previous convictions for serious assaults on female victims.

The first officer at the scene was told by the tenant that there had been a physical altercation the day before during which the boyfriend pushed the decedent. At some point in the evening prior to the death, the TBPS Gang Unit had been called to the apartment and removed the boyfriend and male friend for being loud and rowdy. There was no reported follow up with the Gang Unit. No timelines or status relating to the decedent and involved persons were developed.

FIU member noted injuries on the decedent, including dried blood around her nostrils, some bruising or trauma to the left ear, some dried blood on the back of her left hand and a large bruise to her left shin.

A neighbor was interviewed and reported that everyone in the home was drinking heavily and that he observed the boyfriend push the decedent off the bed with his foot and arguing between the two. Another neighbor reported arguing between the decedent and the boyfriend and observed the boyfriend nudging the decedent with his foot while she lay on the mattress and calling her a “slut.” No further canvass was reported. No background checks. No MCM.

A post-mortem examination was conducted in Toronto. Cause of death was attributed to acute subdural hematoma due to, or as a consequence of, blunt impact head trauma. TBPS added a Supplementary Report indicating that the pathologist described the brain bleed as something that would not have occurred immediately and was caused by an unknown mechanism.

This case was recently reviewed in 2021 by an independent pathologist who advised that this type of bleeding would have led to death over a period of hours. The original coroner indicated that a fall was the most likely explanation of injury because no reported significant altercations or assaults were conveyed. The manner of death was deemed accidental.

A case conference between the original regional coroner, investigating coroner, pathologist and TBPS members occurred. The RMS Supplementary Report for the case conference indicated a report of an argument the night before and the decedent being pushed to the floor, but not striking her head.

VULNERABLE MISSING PERSON CASE

P.K. (deceased 2012)

In the interest of public safety, the BIT recommends a Coroner review of a vulnerable missing person case where the decedent was an Indigenous person. It is understood through the BIT reinvestigation process that the TBPS has improved their missing person policies since 2016, however this case demonstrates the degree of vulnerability Indigenous peoples with mental health needs can face in Thunder Bay and the need for attention to be brought to missing persons cases of Indigenous peoples of all ages.

Reasons that Warrant Further Coroner Review

This case alone, or along with others, should be considered by the EGC for referral for Inquest or a Coroner's Review. Four of the ten deaths identified by the OIPRD began as missing persons investigations. There will be additional comments included in those case reports relating to the TBPS missing persons investigations. However, all four of those deaths started as missing youth cases and reviewed as part of the Seven Youth Inquest.

In 2013, over six months after the decedent went missing, female human remains were found, by the property owner, off a pathway behind a residence approximately 500-750 metres straight-line from where the deceased went missing (hospital). The scene was released within hours of the discovery. Minimal investigation occurred into the death investigation. Arrangements were made for dental comparisons to confirm identity.

No post-mortem results were reported on RMS. No RMS report confirmed that the found remains were those of the decedent. Cause and manner of death are undetermined.

Case Summary and Investigative Shortcoming

This is the 2012 death of a 42-year-old Indigenous female found deceased outdoors near the Thunder Bay hospital (TBRHSC). The decedent was an involuntary patient in

the Adult Mental Health Ward. She walked away from the hospital at approximately 9:00a.m. At 2:41a.m. the following morning TBPS were notified of her being a missing person. The decedent required medication and had limited mobility. The temperature was 1 degree Celsius at the time. The decedent should have been immediately identified as being at high risk.

A three-line narrative Missing Person Report was created, indicating a warrant for apprehension under the *Mental Health Act* was in place and that a possible destination for the missing person was Geraldton, which is 277km east of Thunder Bay. No further action was taken. Speaking with family members, reviewing hospital surveillance video, a hospital grounds search and a media release could have all assisted in locating the decedent early while she was alive.

Four days after the decedent disappeared, the hospital contacted the police to indicate that the decedent had been deemed a voluntary patient and was shown as discharged, cancelling the warrant for apprehension. It is suspected by BIT members that this may have been done as a procedural step to allow the hospital to reassign the decedent's bed. She remained a missing person at high risk. A TBPS Detective (supervisor), in turn, deemed the decedent to no longer qualify as a missing person and had her removed from CPIC. He notified the front desk staff of the same.

Ten days after the decedent went missing her daughter contacted TBPS to advise that the missing person had not been located anywhere since walking away from the hospital. TBPS created a second report showing the decedent as missing on their RMS and CPIC. The family continued to question the investigation.

Around the same time a witness contacted TBPS and advised that the last time the decedent went missing from the hospital, she was located behind TBRHSC in a wooded area. There was still no search effort of any sort. No witness statement was taken.

Twenty days after the disappearance, a media release was issued. Twenty-one days after the decedent went missing the TBPS Chief of police directed that a ground search for her take place.

Twenty-nine days after the decedent went missing TBPS added an RMS report that stated the decedent shuffled her feet and did not take full steps; that she mumbled when she spoke and did not function at an adult level mentally; her condition was exaggerated when she did not take her daily medications; she suffered seizures and without her medication would likely be in medical distress and acting erratically; and that the decedent's family believed she was better off in a secure institution because she could not care for herself.

Thirty days after the decedent first walked away from the hospital a police ground search occurred. TBPS directed the search to utilize a 250-metre outer radius line from the hospital. The Lakehead University grounds adjacent to the hospital property were also searched, all with negative results. No further ground search was ever conducted. No additional action was taken in the missing person investigation.

Expert Consultation on Missing Person Investigation

An OPP Emergency Response Team Staff Sergeant was consulted in relation to this missing person investigation and provided a scenario with similar information, a layout of the TBRHSC property and asked the typical OPP response. Based on the decedent's mental health status, need for medication, seizures, outside weather/temperature and previously being located in the wooded area behind the TBRHSC, the ERT Search Master would initiate a search for the missing person immediately.

The Search Master would ensure that a uniform member attended the scene and confirmed that the missing person left the area on foot, possibly through interviewing persons there or viewing video surveillance footage. Consideration would be given for uniform mobile patrols along the roadways near the hospital. In this circumstance, given the delay in reporting by TBRHSC, that may not have been as fruitful.

The Search Master would ensure a media release had been prepared and circulated, as well as checks with taxi companies and public transportation officials. OPP ERT Search Masters would consider accessing the helicopter or remote piloted aerial system (drone), however those options may not be available to TBPS without requesting outside assistance.

The Search Master would focus on prior instances of wandering and where the missing person was previously located and focus a portion of the current search in that area. The Search Master would focus initially on the hospital grounds, outbuildings and immediate bush areas with the use of a canine member and handler.

After reviewing satellite imagery of the area, the Search Master identified the wooded area to the east of the hospital as a high-priority area, with a significant hazard being the McIntyre River that runs through the forest. The highest priority area would be searched by two teams during the first operational period of the search, with one team north of the river and one team south of the river.

Based on the OPP Search and Rescue training, the radius of a search for a missing person with mental health issues is 2.3km. Given the OPP anticipated search response and the ultimate outcome of this incident, there is a high percentage chance that she would have been located in a reasonable time frame.

FATAL DRUG OVERDOSE CASE

N.C. (deceased 2019)

In the interest of public safety and as a result of BIT analysts seeing a large volume of fatal drug related sudden death cases in the TBPS RMS, the BIT would like to highlight a fatal drug overdose case for consideration for a Coroner review.

Reasons that Warrant Further Coroner Review

Drug overdose deaths are increasing in Thunder Bay and in many other areas of the Province. Furthermore, through this RMS additional cases search, Indigenous persons appear to be at an increased risk in Thunder Bay. The lack of resources and strategies to properly investigate and curb these occurrences have become a significant threat to public safety that requires further review and direction. There are no reports in the RMS of any meeting of the TBPS Sudden Death Review Committee in relation to this case (as per TBPS Sudden Death policy direction).

Case Summary and Investigative Shortcoming

This is a 2019 death of a 36-year-old female found deceased in an apartment in Thunder Bay. TBPS were called to check on the decedent's well-being. The apartment door was unlocked and damaged. This damage was not investigated further.

The decedent was located obviously deceased, face-down on her bed. She was holding a lighter and a make-shift pipe in her right hand. Blood on the top sheet of her bed, under her right wrist, as well as a ring of fluid under the decedent's head. Lividity appeared to have set in. A uniform officer spoke to the downstairs tenants and they described hearing people in the decedent's apartment at approximately 4:00am on that date.

Coroner attended the scene and immediately indicated that it would be a coroner's case, no foul play suspected and believed it to be a drug overdose. There appeared to be no consideration by police or the coroner about seeking the source of the drugs and

determining if Criminal Code charges, such as manslaughter or criminal negligence causing death, may be applicable after some investigation. Several mugs were located on the living room table, partially full. They were not seized for any analysis, including DNA, to determine who may have been present in the apartment.

Evidence was present that a female suspect and two other males (persons of interest) had been at the apartment at the time of death. Further information was received that female suspect was at a fatal overdose in Thunder Bay during the summer of 2019 and that she had been present at a minimum of two other fatal overdoses. As well, there was information that the female suspect used fentanyl and robbed local drug houses.

A witness described two suspicious vehicles close to the apartment and provided the license plates. He suggested the one vehicle may have been the vehicle belonging to the decedent's drug dealer. No follow up was reported on these license plates and no statement was taken from the witness.

No analysis was completed on the seized cellphone belonging to the decedent nor the cell phone in possession of the decedent's father to determine conversations prior to her death. Evidence was reported to be available on Facebook. There was no report of a consent covert online takeover by police of the witness' Facebook account in order to communicate with the suspect further about the death.

Almost two months after the death, TBPS interviewed the suspect. She confirmed that she provided the drugs "down" (believed to be fentanyl) to the decedent, suspect and two other males consumed the night of the death. The suspect was questioned why she was associated with several other overdose incidents. She responded by saying that she has a very high tolerance of opioids, that the drug used on the night in question were "real good" and that the decedent did not use these drugs often.

Very few of several key witnesses were interviewed in this investigation. Two persons of interest were never spoken to or eliminated. No MCM. The decedent's father was

frustrated that he was told, less than a day after the death, that the investigation was wrapped up and that the decedent was alone when she died. He later complained that there was no progress on the police investigation into his daughter's death. He told police that he received information that the suspect had shot up a male with cocaine and then robbed him.

Toxicology report of the deceased showed a fentanyl level of 20 ng/mL (fatal reference is >3 ng/mL); as well as various levels of cocaine, benzoylecgonine, amphetamine, morphine and ethanol. The cause of death reported by the pathologist was mixed drug toxicity – fentanyl, cocaine, amphetamine, ethanol and morphine, dated 10 March 2020.

Manner of death is accidental.

A further background check by the BIT members confirmed that the suspect was associated to a drug related homicide and two other overdoses. The suspect and two persons of interest all appear connected to the drug subculture in Thunder Bay and have various drug related criminal convictions, including trafficking and possession for the purpose of trafficking.

Addendum Case #1

V.K. (deceased 2006)

Recommended Disposition

Referral to Police and Coroner/Pathologist as per input provided in the reviewer comments on the case review tool, “Need to revisit as there is a history of intimate partner violence, lack of information that could have been provided by the daughter, lack of witness statements, and the partner was alone with the decedent - if further information was collected it is likely possible that manner of death could change.”

Case Summary and Investigative Shortcoming

This is the 2006 death of a 37-year-old Indigenous female found dead on her bedroom floor in the City of Thunder Bay. First responders observed a wire cable wrapped around the decedent’s neck. The cable appeared to have been cut, with a matching piece of cable attached to a ceiling fan above the decedent’s body. The death was investigated as a hanging suicide.

Rigor mortis was noted, and no visible injuries were recorded at scene. The decedent’s husband was the complainant. He has a history of violence that includes assault charges. He reported that he and the decedent had been drinking earlier in the day and evening. They engaged in a violent altercation after she disclosed having an extra marital affair. He admitted assaulting her, including punching her to the back of her head with a closed fist. The decedent’s shirt was torn.

The husband reported that the decedent stated that she was going to hang herself. This was never confirmed by the couple’s fourteen-year-old daughter who became scared and left the home shortly thereafter. The decedent allegedly locked herself in the bedroom. The husband reported he left the home to go drink at a nearby establishment at approximately 10:30 pm and returned home around 2:30 am.

Three neighbours in the apartment below the decedent's home reported they returned home at 11:30pm and heard thumping and thrashing upstairs, followed by a sound like a body slamming above them between 1:15-1:30am. The area of the noise coincided with the upstairs master bedroom. Crying was heard and twenty minutes later the police arrived. The same neighbours indicated that it was normal behavior for the couple to fight all the time. This time frame is concerning because the husband indicated that he was not home at that time and the decedent was alone.

The husband reported that when he returned home from the bar, the bedroom sounded quiet, and the door was locked. He used a screwdriver to gain entry and observed the decedent hanging from a cord below the ceiling fan. He believed she was standing vs seated. However, he was unclear in his recollection. He used a knife to cut the decedent down. He stated he placed her on the floor and began chest compressions, but quickly realized she was deceased.

Photographs were taken of the scene. The Coroner attended the scene and made observations. An autopsy was ordered, and the scene was requested to be held until after the post-mortem examination was completed.

A post-mortem examination was completed at TBRHSC. The examination revealed a small contusion on top of the victim's skull which did not cause any associated bleeding or bruising to adjoining tissue. The cause of death was deemed asphyxiation due to hanging. Pathology and Coroner reports were archived and not available for review by the BIT at the time of reporting.

The decedent was described as very happy about a new job she had started at the Indian Friendship Center shortly before her death. The neighbours, family, bar staff/patrons, and other known witnesses were not formally interviewed to confirm key events reported by the husband. Related video and taxi records were not secured. The husband's call to 911 was not secured.

The husband's account of the evening is confusing and warranted further interview/interrogation and follow up investigation. There was no testing conducted to determine if the ceiling fan, in fact, could hold the weight of the decedent.

No witness statements were recorded on RMS except the husband's video statement. Limited background information about the decedent and her husband was reported. Limited RMS reporting reflecting an incomplete investigation.

This death should have been investigated as a Major Case from the onset.

Addendum Case #2

L.A. (deceased 2013)

Recommended Disposition

Referral to Police and Coroner/Pathologist as per input provided in the reviewer comments on the case review tool, “In review, there is a statement that after case conference with police, coroner, pathologist, fall was concluded but since police investigation and interviews was nowhere near robust it would be difficult to conclude her injury was from a fall considering who she was with that day and without extra information from witness statements (which were not collected)”. Additional reviewer comments include, “This case should be peer reviewed by a Category A Forensic Pathologist. If possible, a neuropathologist should review the slides and any remaining brain tissue (if available) to help with timing of injury, and possible re-bleeding of pre-existing sub-dural hematomata.”

Case Summary and Investigative Shortcoming

This is a 2013 death of a 48-year-old Indigenous female found deceased lying on the ground in a park in the City of Thunder Bay. EMS located the decedent, alone, face down under a park bench. There were no obvious signs of injury or trauma.

Officers patrolled the park and located three males who had been drinking together and in the area before the decedent was found. One of these witnesses indicated that he was the decedent’s boyfriend (also referred to as the common law spouse by the coroner). He had been drinking with her in the park earlier. He advised that the decedent fell over and that sometime after, he could not wake her up. He left her unattended, lying on the ground.

There are several inconsistencies in the boyfriend’s statements. He also has a record of assault, assault with a weapon and sexual assault. Police documents indicate natural causes as the suspected cause of death early in the investigation. Scrapes were

identified and photographed on the decedent's knees while her body was at the Thunder Bay Regional Health Sciences Center.

Several witnesses were identified; however, it appears that only the boyfriend was formally interviewed. He was not interrogated or asked to participate in a polygraph examination. Video surveillance believed to be available of the area at the time of death and to corroborate witness information was not reviewed or secured.

Several items were collected as evidence in the area where the decedent's body was located, including an LCBO bag and receipt from that day, a plastic Root Beer bottle, a plastic water bottle, and three Lifestyle condoms sealed in a package together. DNA examination/testing was not conducted on exhibits secured at the scene.

Several critical witness interviews were not conducted. TBPS RMS reporting is lacking. Little to no background information relating to the decedent and her boyfriend was reported. No timelines were established/confirmed. The police investigation, as reported, is incomplete. This investigation should have been treated as a Major Case from the onset.

A postmortem examination was conducted in Thunder Bay. No scene photos were available, nor were there any TBPS members in attendance. No photos were taken at the postmortem examination. There was a contusion in the occipital scalp visible on reflecting the scalp. On opening the skull there was a fresh subdural hematoma on the right side, volume at least 150 cc. Previous head injuries were noted in the Pathology Report. There is no mention of a sexual assault examination having been conducted.

The original pathologist's opinion was listed as:

> *1. This 48-year-old Aboriginal female died as a result of brain herniation following a fresh subdural hematoma.*
> *2. The hematoma was most likely due to blunt head trauma to the occiput, which could have been due to a fall.*

3. Toxicology results indicate that she had been drinking alcoholic beverages prior to death.

4. She may have had a hemorrhagic diathesis due to severe fatty liver disease.

5. The fractured ribs were most likely due to cardiopulmonary resuscitation.

A case conference was called due to the cause of death being a subdural hematoma. RMS indicates that the coroner wanted two additional unnamed witnesses interviewed. The coroner ruled the death accidental due to one or more falls while intoxicated.

Regional Supervising Coroner's note: *full investigation by police, coroner, pathologist, with a case conference to go over findings did not determine any external factors or foul play in this death. There was no evidence of assault or altercation from the scene, witness statements, the body or postmortem. She had been intoxicated with alcohol and had frequent falls. Exactly where and when the fall occurred, that led to her death, is not known.*

Addendum Case #3

C.A. (deceased 2014)

Recommended Disposition

Referral to Police (external review) and Coroner/Pathologist as per input provided in the reviewer comments on the case review tool, “Why did coroner not attend the scene with this circumstance? Had investigation by police been more robust – any consideration to change manner?” Additional reviewer comments included, “Vitreous fluid should have been sent for analysis. Otherwise, the coroner and forensic pathologist investigations are appropriate for the case.”

Case Summary and Investigative Shortcoming

This is a 2014 death of a 34 yr. old Indigenous male found face down in a ditch near Fort William Road in Thunder Bay. The complainant was walking along Fort William Road near Starbucks and observed the victim in the ditch, approximately ten feet deep off the roadway and called 911 at 7:43 am.

The responding officer reported that it appeared the victim had slipped and fallen into the ditch and was unable to get out. A partially full Tim Hortons coffee was observed on a concrete sign base beside the ditch where the victim had been located. As well, slide or skid marks into the ditch were noted in the area where the decedent was located.

There was a reference in the Sudden Death TBPS RMS report that the nearby Starbucks was canvassed and had no outside video surveillance. Further, the Canadian Tire Gas Bar said they would pull outside video cameras in the area between 4:00-8:00am. It would have been valuable to this investigation to check for video at the nearest Tim Hortons to attempt to locate the victim making a purchase. It could have helped determine if the victim was alone or in company of others. As well, that information could have assisted with a timeline for this incident.

The decedent was transported by ambulance to TBRHSC where he was pronounced dead at 8:51am. The investigating coroner did not attend the scene, nor did he order a post-mortem examination for the death of this 34-year-old male who was, otherwise believed to be in good health. However, toxicology results were requested.

Water was observed at the bottom of the embankment and there were visible clothing patterns in the snow. The ice was broken at the bottom of the ditch and it was believed that the victim's feet had broken the ice and went into the water.

An RMS supplementary report stated that if the victim had a medical issue or was intoxicated, he may not have been able to get out of the ditch. Photos were taken of the scene, as well as the victim at TBRHSC. No injuries were observed on the decedent's hands or face.

A separate RMS supplementary report indicated that the ditch was frozen at the bottom, except where the decedent had been located. Three sets of tracks were noted in the embankment. The first was attributed to the EMS and Fire Department personnel. A second set that went halfway down the ditch, were assumed to be from the complainant who called 911. The third set was believed to be from the decedent when he slid down the snowbank into the water.

It is concerning that the second set of footprints was left to the assumption that the complainant walked part way down the embankment prior to calling 911. No formal statement was ever taken from the complainant to confirm that, nor was the area canvassed further.

The Tim Hortons and Canadian Tire Gas Bar videos may have assisted with determining if the decedent was alone while walking down Fort William Road, neither videos were obtained for review by TBPS.

Further, no witness statements were obtained to help track the decedent's movements prior to going into the ditch. It appears an assumption was made from the onset by police and the coroner that the decedent had a medical event or was intoxicated and fell down the ditch and was unable to get himself out. There was no mention in police reports about the possibility that the decedent was assaulted or pushed into the ditch by another person. No investigative follow up was conducted to disprove this equally possible explanation for the circumstances.

The toxicology results that had been requested by the coroner were not reported on RMS. No further reports were on RMS and there was no Coroner report available as the decedent died in hospital.

A check of historical temperature data through Environment Canada showed temperatures in Thunder Bay on the date of the death at 7:00 am as negative 4.3 degrees Celsius (temp) and negative 5.2 degrees Celsius (dew point temp).
The OCC information obtained by Broken Trust investigators indicated the cause of death as hypothermia.

There was no background information in the RMS reports to describe the decedent, his habits, associates, whereabouts leading up to his death. This investigation overall was incomplete and left many questions unanswered. It should have been treated as Major Case Management from the onset.

Addendum Case #4

N.F. (deceased 2019)

Recommended Disposition

Referral to Police (external review) and Coroner/Pathologist as per input provided in the reviewer comments on the case review tool, “No autopsy report was provided. Given the nature of the case and concerns regarding elder abuse/neglect, this should be reviewed by a Category A Forensic Pathologist.”

Case Summary and Investigative Shortcoming

This is the 2019 death of a 61-year-old indigenous female in her residence in the City of Thunder Bay. TBPS responded to a call from the decedent’s common law partner and only other resident and person present at the time of death.

No signs of injuries were noted by initial responders. The decedent was described as schizophrenic as well as extremely thin and frail (emaciated) weighing between 70 and 80 lbs. TBPS CIB was notified, determined that there was no foul play and did not attend the death scene. TBPS FIU secured photographs of the scene and the victim while at hospital. The coroner did attend the scene.

Post-mortem conducted in Thunder Bay. No definitive cause of death, metabolic acidosis due to starvation and chronic upper gastral intestinal bleeding noted.
The decedent’s mother reported to TBPS that she believed the common law partner (complainant) withheld medication and killed her daughter by starving her to death. She also provided allegations of physical abuse on a regular basis. There is a history of domestic violence to corroborate these concerns. TBPS did not respond to the mother’s initial complaint.

The decedent’s mother sent a second complaint request. Eventually, over three months after the death, TBPS spoke with the mother, who advised at that time that the decedent had told her shortly before the death, “He is going to kill me” and described

how the common law partner controlled phone access for the decedent and visitation by outsiders, including family. This information was forwarded to TBPS CIB by the uniform officer and there is no indication of follow up.

Little to no background information about the decedent and her common law husband was reported. There were two case conferences held on this investigation in 2020 including the investigating coroner, Regional Coroner, TBPS D/Cst and pathologist – discussions on starvation, neglect and concerns by the mother were documented.

The common law partner and only person present at the time of death does not appear to have been formally interviewed or interrogated. Neighbours and the immediate area of the residence was not canvassed. Other key interviews of friends, family and associates did not occur. Investigation was not treated as a Major Case and was left incomplete in several areas.

BIT RECOMMENDATIONS

As a result of the key findings, identified themes and in addition to the concerns highlighted in individual cases included in this report, the following recommendations are for EGC consideration:

Recommendation #1: Police led further investigations into the manner of death of 14 additional cases identified as cases that warrant further investigation and where the decedent was either an Indigenous female or an Indigenous male.

Recommendation #2: In the interest of public safety, a Coroner review of a vulnerable missing person case where the decedent was an Indigenous person.

Recommendation #3: In the interest of public safety and as a result of the BIT analysts seeing a large volume of fatal drug related sudden death cases, a Coroner review of a fatal drug overdose case.

Recommendation #4: As observed by the BIT, there appears to be a high volume of inconsistent classifications of sudden death investigations, inconsistent records management, poor documentation of records and concerning cases that may require additional review, however are not part of the TOR guidelines, therefore an external audit of the TBPS RMS as it relates to death investigations take place.

CONCLUSION

The IRC raised a concern with the BIT that there are several outstanding Missing and Murdered Indigenous Women and Girls (MMIWG) cases with the TBPS. It was confirmed by the TBPS to BIT members that there are 25 MMIWG unsolved cases sitting with the TBPS Criminal Investigation Branch. Some of these MMIWG cases predate 2000 and have remained open and unresolved for over 20 years. The BIT has not reviewed the 25 unresolved MMIWG cases and would like to bring these cases to the EGC in consideration for review.

To reiterate, due to limited realities (time and resources), it is asked that this report be reviewed as a **snapshot into the TBPS RMS** and investigative concerns documented here. It appears that in Thunder Bay there are a higher number of sudden deaths and/or homicides where the decedents are Indigenous, as well as a large volume of Indigenous decedents where the manner of death is accidental or undetermined.

To support observational findings highlighted in this report and to help put numbers to this understanding, it is suggested that the EGC consider further analytical work with OCC data and Statistics Canada data to support evidence-based findings in the final report. The BIT has analytical products on file that are not applicable to the additional cases report, therefore were not included here. However, the analytical products may support the EGC's final report if needed.

As mandated in the TOR, the BIT review identified additional cases that warrant further investigation using the criterion listed in this report. It is the BIT understanding that the reported manner of death is not supported factually by the investigations described in some RMS reports and other readily available TBPS and coroner information. It is advised that the cases identified in this report are secured and preserved by the TBPS pending further direction by the EGC or the OIPRD on further investigation. The standard that was applied to identifying additional cases in this report may be considered by the EGC in response to the OIPRD's recommendation #3.