THUNDER BAY POLICE SERVICE DISCIPLINE HEARING
IN THE MATTER OF ONTARIO REGULATION 268/10

MADE UNDER THE *POLICE SERVICES ACT*, RSO 1990,
AND AMENDMENTS THERETO;

AND IN THE MATTER OF
THUNDER BAY POLICE SERVICE
AND

STAFF SERGEANT SHAWN HARRISON #601
SERGEANT SHAWN WHIPPLE #343

CHARGES:
HARRISON - NEGLECT OF DUTY & DISCREDITABLE CONDUCT
WHIPPLE - NEGLECT OF DUTY & DISCREDITABLE CONDUCT

DECISION WITH REASONS

Before:	Superintendent (Ret.) Greg Walton
Counsel for the Prosecution:	Mr. Joel Dubois Ms. Veronica Blanco Sanchez
Counsel for the Defence:	Mr. David Butt
Public Complainant:	Mr. Brad DeBungee Mr. James Leonard
Represented by:	Ms. Asha James Ms. Amanda Micallef
Hearing Dates:	May 30, 31, June 1, 2, 6, 7, 16 & 17, 2022

BACKGROUND

On Monday October 19, 2015, Stacey DeBungee was found deceased in the McIntyre River in Thunder Bay. Officers from the Thunder Bay Police Service attended, investigated, and determined the death was not suspicious in nature; foul play was not suspected.

There are two public complainants in this matter. The Office of the Independent Review Director (OIPRD) received a complaint on March 18, 2016, on behalf of Brad DeBungee, brother of Stacey DeBungee, and from James Leonard, Chief at the time, of the Rainy River First Nation. The complaints alleged a negligent police investigation. The subsequent investigation by the OIPRD resulted in the matters before this tribunal.

In the Notice of Hearings, the name Stacey DeBungee is anonymized as S.D. Counsel agreed that Stacey DeBungee ought to be properly identified on the record, thus, his full name appears in this decision. In the material provided to this tribunal and marked as exhibits, Stacey DeBungee is spelled in several different ways. In this decision, I have relied on the spelling provided to the tribunal by Brad DeBungee and his counsel.

The complaints stem from alleged behaviour in 2015 into 2016. The police rank of some of the involved officers has changed since that time. In the exhibits, officers are referred to at the various ranks they held at particular times during the events in question and during the subsequent internal investigation. Shawn Harrison for example, held the rank of detective at the time of this incident, but currently holds the rank of staff sergeant. In the Thunder Bay Police Service, the rank of detective sergeant is equivalent to that of staff sergeant, the rank of sergeant is comparable to detective. The use of detective denotes the officer being in an investigative capacity as opposed to the role of a uniformed officer. At the time of this incident, Shawn Whipple held the rank of detective constable but since then, has held the ranks of sergeant and detective; he is currently a sergeant. For ease of reference, in this decision the officers will be referred to at the ranks that they currently hold. Staff Sergeant Harrison and Sergeant Whipple will be referred to as staff sergeant and sergeant respectfully

Initially, a third officer associated to this incident faced one count of neglect of duty. The officer satisfied first appearance obligations on March 6, 2021 and was represented by counsel during numerous subsequent conference calls. The officer retired from the Thunder Bay Police Service on April 30, 2022, resulting in a loss of jurisdiction.

Of note, this hearing occurred in-person in Thunder Bay, and was live streamed on You Tube in its entirety. Final submissions were a hybrid of in-person and virtual appearances, but they were also live streamed.

THE HEARING

Allegations of Misconduct (amended)

Staff Sergeant Shawn Harrison – Count #1 – Neglect of Duty

It is alleged that in the course of Staff Sergeant Harrison's involvement with the Stacey DeBungee sudden death investigation, specifically between the dates of October 19, 2015 and March 18, 2016 while a member of the Thunder Bay Police Service, he did commit misconduct by neglect of duty in that he did without lawful excuse, neglect or omit to promptly and diligently perform a duty as a member of the police force of which the officer is a member of, contrary to Subsection 2(1)(c)(i) of the Conduct of Conduct, Regulation 268/10 of the Revised Regulations of Ontario, as amended, contrary to Section 80(1)(a) of the *Police Services Act,* R.S.O. 1990 as amended.

Statement of Particulars:

It is alleged that as the lead investigator, Staff Sergeant Harrison failed to properly investigate the Stacey DeBungee sudden death by not treating and investigating the sudden death as a potential homicide. Deficiencies include, but are not limited to:

- The sudden death was not investigated as per the Major Case Management system.
- Prematurely concluding that the death was non-criminal when the evidence did not support the conclusion that foul play had been excluded .
- Failure to adequately direct the Forensic Identification Unit which resulted in a lack of documentation and photographs of the scene.
- No forensic examination occurred of the exhibits.
- Approving media releases that indicated the death was "deemed non-criminal" and that "no foul play" was suspected, prior to having the evidence to support this conclusion.
- Failure to formally interview persons who had been in the company of Stacey DeBungee shortly before his death.
- Failure to conduct formal follow up interviews with several witnesses.
- Failure to review reports in the investigative file on an ongoing basis.
- Not contacting a material witness in a timely manner and only contacting them a long time after the material event.

Staff Sergeant Shawn Harrison – Count #2 – Discreditable Conduct

It is alleged that in the course of Staff Sergeant Harrison's involvement with the Stacey DeBungee sudden death investigation, specifically between the dates of October 19, 2015 and March 18, 2016 while a member of the Thunder Bay Police Service, he did commit misconduct by discreditable conduct in that he failed 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, contrary to Subsection 2(1)(a)(i) of the Conduct of Conduct, Regulation 268/10 of the Revised Regulations of Ontario, as amended, contrary to Section 80(1)(a) of the *Police Services Act,* R.S.O. 1990 as amended.

Statement of Particulars:

> It is alleged that in the course of his involvement with the Stacey DeBungee sudden death investigation, Staff Sergeant Harrison failed to treat or protect persons, specifically the deceased and his family, equally, without discrimination with respect to police services because of his Indigenous status. As a police officer, Staff Sergeant Harrison has an obligation to treat and protect everyone equally. Staff Sergeant Harrison failed to do so when he made assumptions as to the cause of death, did not investigate the sudden death properly, and in his treatment of the complainants throughout his dealings with them.

Sergeant Shawn Whipple – Count #1 – Neglect of Duty

It is alleged that in the course of Sergeant Whipple's involvement with the Stacey DeBungee sudden death investigation, specifically between the dates of October 19, 2015 and March 18, 2016 while a member of the Thunder Bay Police Service, he did commit misconduct by neglect of duty in that he did without lawful excuse, neglect or omit to promptly and diligently perform a duty as a member of the police force of which the officer is a member of, contrary to Subsection 2(1)(c)(i) of the Conduct of Conduct, Regulation 268/10 of the Revised Regulations of Ontario, as amended, contrary to Section 80(1)(a) of the *Police Services Act,* R.S.O. 1990 as amended.

Statement of Particulars:

> It is alleged that in the course of his involvement, Sergeant Whipple failed to properly investigate the Stacey DeBungee sudden death by not treating and investigating the sudden death as a potential homicide. Deficiencies include, but are not limited to:
>
> - The sudden death was not investigated as per the Major Case Management system.
> - Prematurely concluding that the death was non-criminal when the evidence did not support the conclusion that foul play had been excluded .

- Failure to adequately direct the Forensic Identification Unit which resulted in a lack of documentation and photographs of the scene.
- No forensic examination occurred of the exhibits.
- Approving media releases that indicated the death was “deemed non-criminal” and that “no foul play” was suspected, prior to having the evidence to support this conclusion.
- Failure to formally interview persons who had been in the company of Stacey DeBungee before his death.
- Failure to conduct formal follow up interviews with several witnesses.
- Failure to review reports in the investigative file on an ongoing basis.
- Not contacting a material witness in a timely manner and only contacting them a long time after the material event.

Sergeant Shawn Whipple – Count #2 – Discreditable Conduct

It is alleged that in the course of Sergeant Whipple’s involvement with the Stacey DeBungee sudden death investigation, specifically between the dates of October 19, 2015 and March 18, 2016 while a member of the Thunder Bay Police Service, he did commit misconduct by discreditable conduct in that he failed 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, contrary to Subsection 2(1)(a)(i) of the Conduct of Conduct, Regulation 268/10 of the Revised Regulations of Ontario, as amended, contrary to Section 80(1)(a) of the *Police Services Act,* R.S.O. 1990 as amended.

Statement of Particulars:

> It is alleged that in the course of his involvement with the Stacey DeBungee sudden death investigation, Sergeant Whipple failed to treat or protect persons, specifically the deceased and his family, equally, without discrimination with respect to police services because of his Indigenous status. As a police officer, Sergeant Whipple has an obligation to treat and protect everyone equally. Detective Whipple failed to do so when he made assumptions as to the cause of death, did not investigate the sudden death properly, and in his treatment of the complainants throughout his dealings with them.

Plea / Representation

Mr. David Butt represented Staff Sergeant Harrison and Sergeant Whipple. On May 30, 2022, Staff Sergeant Harrison entered a plea of guilty to neglect of duty and a plea of not guilty to discreditable conduct. Staff Sergeant Harrison indicated that while he was admitting to misconduct, his plea was based on the information contained in the Agreed Statement of Facts, he did not admit to all the allegations contained in the Particulars of Allegations; the

guilty plea was specific to not contacting a civilian person (David Perry) who offered to share relevant information with police. A finding of guilty was reserved pending the completion of the hearing.

On May 30, 2022, Sergeant Whipple entered a plea of not guilty to neglect of duty and a plea of not guilty to discreditable conduct.

Mr. Joel Dubois, assisted by Ms. Veronica Blanco Sanchez, represented the Thunder Bay Police Service as prosecutors. Ms. Asha James and Ms. Amanda Micallef represented the public complainants, Brad DeBungee, and James Leonard during the 8-day hearing.

Finding

Based on the standard of clear and convincing evidence, the following findings relate to Staff Sergeant Harrison:

1) Neglect of Duty – guilty
2) Discreditable Conduct – guilty

Based on the same standard of clear and convincing evidence, the following findings relate to Sergeant Whipple:

1) Neglect of Duty – not guilty
2) Discreditable Conduct – not guilty

Agreed Statement of Facts

Exhibit #4 is a 22-page Agreed Statement of Facts dated May 30, 2022, and signed by Mr. Dubois, Staff Sergeant Harrison, Sergeant Whipple, and Ms. James on behalf of Brad DeBungee and James Leonard. Mr. Dubois submitted a Book of Documents to accompany the Agreed Statement of Facts. Exhibit #5 is volume I of the Book of Documents, tabbed 1-30. Exhibit #6 is volume II of the Book of Documents. tabbed 31 – 55. Exhibit # 7 is volume III of the Book of Documents and it is tabbed 56 – 65.

The material found at tabs 64 and 65 of Exhibit #7 is distinct, however; the information found in tabs 1 – 63 is in support of the Agreed Statement of Facts and has been admitted for the truth of its content. The reports found at tabs 64 and 65 are marked as Exhibit #7A and Exhibit #7B respectfully. Mr. Dubois and Ms. James sought to have the reports found therein, admitted for the truth of their content. The material did not make up part of the documents supporting the Agreed Statement of Facts and as such, I did not agree to this request; I will address the information found at tabs 64 and 65 in greater detail, later in this decision.

Of note is that five-weeks were set aside for this hearing. I wish to acknowledge and thank counsel for their collective effort dedicated to narrowing the contested issues; the lengthy and detailed Agreed Statement of Facts resulted in a much more efficient hearing process.

The amended Agreed Statement of Facts reads as follows:

> Staff Sergeant Harrison is a staff sergeant with the Thunder Bay Police Service and was a detective at all relevant times. Sergeant Whipple is a sergeant with the Thunder Bay Police Service and was a detective constable at all relevant times.
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> On October 5, 2015, the Chief Coroner for Ontario, Dr. David Eden, began the Inquest into the Deaths of Seven First Nations. This inquest aimed to examine the circumstances surrounding the deaths of seven First Nations youth in Thunder Bay, who had died in similar circumstances and whose causes of deaths were undetermined. The primary purpose of the inquest was to prevent the deaths of First Nation youths.
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> Between October 19, 2015, and March 18, 2016, Staff Sergeant Harrison and Sergeant Whipple were assigned to the Criminal Investigation Branch of the Thunder Bay Police Service. On October 19, 2015, at approximately 9:30 a.m., the Thunder Bay Police Service received a 9-1-1 call from Mr. Carl Sandy reporting a deceased person in the McIntyre River. This deceased person was later identified as being Mr. Stacey DeBungee.
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> Paramedic Simon Butler attended the scene, determined that the deceased was "obviously dead," and did not attempt resuscitation efforts. At approximately 9:32 a.m., uniform officers Constable Jim Lorentz, Constable Bradley Bernst, and Constable Sean Verescak, attended at the McIntyre River, where Stacey DeBungee's body was located.
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> Constable Lorentz took a notebook statement from Mr. Sandy respecting him finding Stacey DeBungee's body. Mr. Sandy indicated he was walking his dog and noticed Stacey DeBungee's body on the river shore, and immediately called 9-1-1. Constable Bernst encountered three individuals on the scene who identified themselves as Corrie Sainnawap, Samaria Etherton, and Adam Achnespineskum. It was later determined that Samaria Etherton is also known as Marie Spence.
>
> Mr. Achnespineskum told Constable Bernst that he was advised by Mr. Sandy that there was a person who had drowned in the river. The three individuals did not know who the person that had drowned was, however the three individuals found a health card by the riverbank.

At approximately 9:40 a.m., Staff Sergeant Harrison, and Sergeant Clark McKever [Sergeant McKever held the rank of detective constable at the time of this incident] attended at the McIntyre River, as members of the Criminal Investigation Branch. Sergeant Whipple arrived on scene at approximately 9:50 a.m.

During the relevant time frame of October 19, 2015, to March 18, 2016, Staff Sergeant Harrison was the lead investigating officer and supervising officer assigned to Stacey DeBungee's sudden death investigation. Sergeant Whipple was part of Staff Sergeant Harrison's investigative team.

Stacey DeBungee's body was found face down in the river shoreline. The river was slow moving and still at the shoreline. An Ontario health card was observed and taken by other officers. The health card belonged to David Sapay.

At approximately 9:55 a.m., Detective Shannon Primmer [Detective Primmer was a Detective Constable at the time of this incident] and Detective Constable Jeff Tackney attended the scene, as members of the Forensic Identification Unit.

Acting Sergeant Kerry Dunning attended the scene, as supervising sergeant. Constable Lorentz and Constable Verescak secured the scene by setting up a perimeter tape. Acting Sergeant Dunning remained outside of the perimeter tape.

Detective Primmer and Detective Constable Tackney of the Forensic Identification Unit identified, photographed, marked, and collected 10 exhibits. They did not collect a video of the scene because it was not considered to be a suspicious death, and video is only taken where it is a suspicious death. Detective Primmer took 45 photographs. None of these focused exclusively on Stacey DeBungee's body.

At approximately 10:42 a.m., the coroner, Dr. Michael Scott, arrived on scene. Shortly thereafter, Constable Verescak, Sergeant McKever, and Detective Constable Tackney removed Stacey DeBungee's body from the river and placed him on his back. There were no visible and clear signs of external trauma to Stacey DeBungee. At this point, at least one officer recognized the deceased as being Stacey DeBungee. There was no determinative identification until approximately 2:50 p.m., when Stacey DeBungee's tattoos were cross-referenced with his Niche RMS [Thunder Bay Police Service Records Management System] tattoo descriptions, and a match was confirmed.

Upon removal of Stacey DeBungee's body, a zip lock bag was found near the body with a second Ontario health card, which belonged to Stacey DeBungee.

Between 10:45 a.m. and 11:02 a.m., Staff Sergeant Harrison noted in his notebook that there was “no obvious signs of trauma/foul play.”

At approximately 11:00 a.m., a civilian, Michael Chartier, approached and spoke to Constable Verescak to inform him that he had seen several “Native Canadians” drinking the previous night at the riverbank, and that he observed two of the males to be in a physical altercation. The two males were not identified by Mr. Chartier in his initial statement, and Stacey DeBungee’s body showed no signs of a physical altercation. Mr. Chartier was not formally interviewed by Staff Sergeant Harrison or Sergeant Whipple, and no steps were taken respecting the potential physical altercation and/or the identity of potential witnesses as reported by Mr. Chartier.

While on the scene, Dr. Scott indicated that an autopsy would be conducted. During his interview with the OIPRD, Dr. Scott stated that it was not wise for the police to characterize the death as “non-criminal” without the benefit of an autopsy.

By noon, Thunder Bay Police Service Executive Officer Christopher Adams attended the scene to assist with media relations. Staff Sergeant Harrison advised Mr. Adams that there were no signs of foul play.

At approximately 12:45 p.m., after obtaining Staff Sergeant Harrison’s approval via e-mail, Mr. Adams issued a press release. Staff Sergeant Harrison approved this media release within three hours of discovering Stacey DeBungee’s body, before conducting an investigation, before positively identifying Mr. DeBungee's body, before an autopsy had been performed, and before locating Mr. Sapay whose Ontario health card was located by Stacey DeBungee’s body.

At approximately 2:14 p.m., resource officer Constable Janine Lewkoski received a telephone call from Cornelius Wapoose, the nephew of Stacey DeBungee’s common law spouse Evelyn Kwandibens, to report that Stacey DeBungee was missing. He, and his sister Ethel Wapoose, indicated that Stacey DeBungee had been in the company of Ethel Wapoose, David Sapay, John Alex Waswa and Corey Linklater the previous night.

At approximately 2:35 p.m., Staff Sergeant Harrison was advised by Sergeant Whipple that Stacey DeBungee had been reported missing.

At approximately 2:50 p.m., Staff Sergeant Harrison officially identified the deceased as being Stacey DeBungee, and he assigned Sergeant Whipple and Sergeant McKever to notify Stacey DeBungee’s next of kin, his common law spouse, Evelyn Kwandibens.

At approximately 3:15 p.m., Sergeant Whipple and Sergeant McKever attended at the residence of Evelyn Kwandibens. Present at the home was also Ethel Wapoose, Cornelius Wapoose, Corey Linklater, and John Alex Waswa.

Ethel Wapoose advised that she had been drinking with Stacey DeBungee as well as with David Sapay, John Alex Waswa, Corey Linklater, Cornelius Wapoose, the previous night. When they left the riverbank, Stacey DeBungee and David Sapay were passed out on the bank.

Sergeant Whipple did not take official statements from Evelyn Kwandibens, John Alex Waswa, Corey Linklater and Cornelius Wapoose nor did he advise the next of kin that the manner of Stacey DeBungee's death could only be determined after the entire investigation was complete.

Staff Sergeant Harrison and Sergeant Whipple did not communicate with Ms. Evelyn Kwandibens after the date of the death notification, nor did they follow-up, contact or interview any of the other individuals who had been with Stacey DeBungee the night prior to his body being discovered.

The next day, on October 20, 2015, Mr. Adams released a second press release relating to the discovery of Stacey DeBungee's body, which stated that "the death has been deemed as non-criminal."

During his interview with the OIPRD, Mr. Adams stated that it is a valid concern expressed by Indigenous people that Stacey DeBungee's death was considered "non-criminal" before an autopsy had been conducted.

Mr. Adams obtained verbal approval prior to issuing the second press release but does not recall if it was from the lead investigator Staff Sergeant Harrison, the Detective Sergeant, or from the Inspector.

During his interview with the OIPRD, Sergeant Whipple stated that the second media release was not reflective of the status of the investigation, and that the autopsy results, once obtained, could take the investigation in a different direction.

Also on October 20, 2015, Sergeant Whipple and Sergeant McKever attended Mr. Sapay's last known home address. Mr. Sapay was not present, but his father was. Mr. Sapay's father indicated that he had not seen Mr. Sapay in a couple of days. Sergeant McKever provided the father with his business card and requested that Mr. Sapay call as soon as possible. Sergeant Whipple recorded this event in his notebook but did not

include any details of this encounter. Sergeant Whipple did not follow-up on Mr. Sapay and made no further attempts to find Mr. Sapay.

Staff Sergeant Susan Kaucharik instructed Staff Sergeant Harrison to initiate a “Be On The Lookout” (BOLO) notice for Mr. David Sapay.

Mr. Sapay called the number indicated in Sergeant McKever’s business card, though he was told that Sergeant McKever was not available. No message was delivered to Sergeant Whipple or Staff Sergeant Harrison. Mr. Sapay did not receive a call back nor was there any other attempt to follow up with Mr. Sapay.

On March 26, 2016, then Chief of Police Levesque informed Sergeant Whipple that it was a problem that Mr. Sapay had not yet been interviewed. Staff Sergeant Harrison and Sergeant Whipple spoke with Mr. Sapay on March 28, 2016, after the OIPRD complaint had been filed. Mr. Sapay had been in the custody of the Thunder Bay Police Service twice in the preceding months and no one had notified Staff Sergeant Harrison or Sergeant Whipple.

On March 28, 2016, Mr. Sapay advised Sergeant Whipple that on the night of October 18, 2015, he was involved in an argument with Corey Linklater. Following the argument, Mr. Sapay went to and stayed at his friend’s residence, Michel Benoit. On March 28, 2016, Sergeant Whipple attended the address provided by Mr. Sapay that pertained to Mr. Benoit. Jerome Junior McWatch answered the door and advised that there was no Michel Benoit at that residence, nor did he know anybody by that name. Sergeant Whipple took no further investigative steps to locate Mr. Benoit.

On October 21, 2015, Constable Mark Cattani advised Sergeant McKever that he had encountered Mr. Corey Linklater at approximately 9:30 p.m. on the night of October 18, 2015.

On October 18, 2015, Constable Cattani and Constable Michael Biloski responded to a call for a *Liquor License Act* complaint. They observed Mr. Linklater and two other individuals who were not identified at the SilverCity Theatre. Mr. Linklater requested a ride from the officers, to which Constable Cattani stated he could not provide that. The officers left.

On October 21, 2015, Staff Sergeant Harrison met with the deceased’s family: Stacey DeBungee’s brother Brad DeBungee, their cousin Karen Williams, and their aunt.

The family members inquired as to whether Stacey DeBungee had been killed. Staff Sergeant Harrison informed the family members that the coroner did not believe that

foul play was involved, but an autopsy was to be performed and a witness was to be interviewed.

Staff Sergeant Harrison advised the family that he did not know how Stacey DeBungee ended up in the river, but one possibility was that he had passed out and rolled down the riverbank, into the river and drowned.

Ms. Williams learned about her cousin Stacey DeBungee's death through word-of-mouth after individuals had seen the news on Facebook, as a result of the Thunder Bay Police Service's first media release. She was concerned that immediate family was not advised of Stacey DeBungee's death prior to releasing the information to the media.

Also on October 21, 2015, Dr. Nicholas Escott conducted an autopsy on Stacey DeBungee's body. Detective Constable Jesse Lepere, who had not attended the scene nor been involved in the sudden death investigation, was assigned by the Identification Detective to attend the autopsy. Detective Constable Lepere took approximately 30 - 50 photographs of Stacey DeBungee's body and sent them to the Centre for Forensic Sciences.

Dr. Escott advised Detective Constable Lepere during the autopsy that drowning was likely, but that the anatomical cause of death would not be determined until toxicology results were received.

The coroner's Postmortem Examination Report dated October 21, 2015, concluded that the immediate cause of death of Stacey DeBungee was "freshwater drowning;" it further stated, "alcohol intoxication as other significant conditions contributing to death, but not causally related to the immediate cause." It does not say the drowning was due to alcohol intoxication.

During his OIPRD compelled interview, Staff Sergeant Harrison stated that the investigation did not fall within the Major Case Model and was not conducted per the Major Case Management policy for that reason. Staff Sergeant Harrison also stated that he did not have the same supervision responsibility as that of a Major Case Manager, as the sudden death was a Coroner's case. No investigative plan was developed by either Staff Sergeant Harrison or Sergeant Whipple relating to this investigation.

In November 2015, approximately one month after Stacey DeBungee's death, his family hired a private investigator, David Perry, from Investigative Solutions Network Inc., to investigate Stacey DeBungee's death.

Mr. Perry conducted an investigation between November 16 and 19, 2015. Mr. Perry interviewed Brad DeBungee, Stacey DeBungee's stepdaughter Kathleen Kwandibens, Stacey DeBungee's close friend Sid Safronyck, and coroner Dr. Michael Scott. This was the first time any of these individuals had been interviewed in an investigative capacity related to Stacey DeBungee's death. None of these individuals had been interviewed by Staff Sergeant Harrison or Sergeant Whipple.

Mr. Perry found that Stacey DeBungee's debit card had been used after his body had been recovered. He was unable to retrieve the relevant bank records.

On November 19, 2015, Mr. Perry attended at the Thunder Bay Police Service and specifically asked to speak to Staff Sergeant Harrison, stating that he "had information relevant to the investigation." Staff Sergeant Harrison refused to meet with Mr. Perry. Mr. Perry left his business card and requested a call back. Neither Staff Sergeant Harrison nor Sergeant Whipple ever contacted Mr. Perry.

Staff Sergeant Harrison and Sergeant Whipple were aware of Mr. Perry's investigation and decided not to meet with Mr. Perry. Staff Sergeant Harrison failed to pursue attaining potentially important information pertaining to Stacey DeBungee's sudden death.

Mr. Perry's investigation found the following:

- Brad DeBungee was very suspicious of Ms. Evelyn Kwandiben's family, as there were concerns of abuse.
- On the night of his death, Stacey DeBungee was called by Ethel Wapoose to withdraw funds from his own bank account that had been transferred by Ms. Wapoose's family.
- There were approximately four individuals with Stacey DeBungee on the night of his death and they were drinking together by the McIntyre River. These were Ethel Wapoose, Corey Linkletter, Wayne and John Alex Waswa.
- There may have been a physical altercation the night of Stacey DeBungee's death in the area where his body was recovered.
- Stacey DeBungee's debit card was used after his death. Ethel Wapoose was in possession of the debit card after Stacey DeBungee's death.
- Ethel Wapoose and Corey Linklater moved away from Thunder Bay shortly after Mr. DeBungee's death and have not been seen since.

On November 24, 2015, Brad DeBungee requested information about his brother's death from Staff Sergeant Harrison.

On March 29, 2016, Staff Sergeant Harrison reviewed the Postmortem Examination Report and the Toxicology Report in relation to the sudden death of Stacey DeBungee. On the same day, Staff Sergeant Harrison submitted a supplementary occurrence report and made notebook entries. In his duty notes, Staff Sergeant Harrison stated that the autopsy report showed “high levels of alcohol in his system.” The notes further state that the cause of death was “fresh water drowning due to/or as a consequence of alcohol intoxication.” Further, the report stated, “thus, as originally reported, DeBungee’s death was not a result of any type of foul play or homicide, it was as a result of drowning due to alcohol intoxication.”

Staff Sergeant Harrison claimed that the cause of Stacey DeBungee’s death was “fresh water drowning due to/or as a consequence of alcohol intoxication,” when the Postmortem Examination Report stated that the cause of death was “freshwater drowning” and that another “significant condition” contributing to the death, but “not causally related” to freshwater drowning, was alcohol intoxication.

On May 12, 2016, Detective Louis Bystrican received a telephone call from Joanne Courchene, who advised that Marie Spence had claimed to be responsible for Stacey DeBungee being in the river. Ms. Courchene advised Detective Bystrican that Ms. Spence stated that she was having nightmares about having been in a “shoving match” with Stacey DeBungee by the river, him ending up in the river, and Ms. Spence was not strong enough to pull him out of the river.

Detective Bystrican informed Staff Sergeant Harrison of Ms. Courchene’s call and relayed the information she provided, in May 2016.

In May 2016 Detective Constable Karen Kerr attempted to contact Ms. Courchene by telephone. No other attempts to speak with Ms. Courchene were made by any officer.

On June 30, 2016, Constable Chris Carlucci was asked by Detective Bystrican to follow up with Ms. Courchene. Constable Carlucci found that Ms. Courchene was in the hospital as a result of a domestic incident. Constable Carlucci attended at the hospital and spoke with Ms. Courchene, who reiterated the same details she had provided to Detective Bystrican.

Ms. Spence had passed away on April 30, 2016, approximately one week prior to Ms. Courchene’s call to the police. Marie Spence is the same individual (Samaria Etherton) that was at the scene of Stacey DeBungee’s death the morning of October 19, 2015, and spoke with Constable Bernst.

On March 18, 2016, Brad DeBungee and the Chief of the Rainy River First Nation, James Leonard, submitted a complaint to the OIPRD.

On August 10, 2016, Detective Bystrican tasked Detective Constable Ken Biloski with finding and interviewing Corey Linklater, John Alex Waswa, and Ethel Wapoose, which were three of the four individuals who had been with Stacey DeBungee on the night prior to his body being discovered.

Staff Sergeant Harrison and Sergeant Whipple had stopped working on the DeBungee investigation in the spring of 2016 after the public complaints were received. On October 27, 2016, Deputy Chief Andrew Hay formally re-assigned the Stacey DeBungee investigation to Detective Sergeant William Wowchuk and Detective Constable Ken Biloski because he was concerned with Staff Sergeant Harrison's and Sergeant Whipple's handling of the investigation.

During Detective Sergeant Wowchuk's and Detective Constable Ken Biloski's investigation, it was the first time that:

- Mr. DeBungee's financial statements were reviewed;
- Evelyn Kwandibens, Corey Linklater, Ethel Wapoose and John Alex Waswa were formally interviewed by the Thunder Bay Police Service in relation to Stacey DeBungee's death investigation;
- Joanne Courchene, her counsellor, and next of kin of Marie Spence, were interviewed with respect to a suggestion made by Joanne Courchene on May 12, 2016, that Marie Spence, who was by that time deceased, had admitted to Joanne Courchene that she caused Stacey DeBungee to fall in the river; and,
- Mr. Chartier was contacted and interviewed regarding his observations on the night of October 18, 2015.

On January 12, 2017, Chief of Police Levesque asked the Ontario Provincial Police to conduct a review of the Thunder Bay Police Service's investigation into the death of Stacey DeBungee. The resulting investigative report pointed out numerous failings of the investigation, namely:

- Initial response:
    - No broad canvass was conducted of local businesses, or a residence situated directly across from the river; and
    - Several witnesses were identified, but not formally interviewed.
- Scene examination:
    - Stacey DeBungee's body was only visible in 11 of 45 photographs taken;
    - None of the 11 photographs showing Stacey DeBungee's body were focused exclusively on the body;
    - There were no photographs focusing exclusively on the riverbank;

    - There was no video taken of the scene;
    - Photographs demonstrate that certain items, such as cigarette butts, visible in the photographs had not been seized; one of the cigarette butts was in close proximity to the health card found at the scene;
    - No measurements were taken with respect to water depth, slope of the riverbank or proximity of exhibits to Stacey DeBungee's body or to suspected entry point;
    - Stacey DeBungee's body was not kept free of contamination when it was moved to the shore;
    - The scene was released the same day, prior to the post-mortem having been conducted;
    - Staff Sergeant Harrison noted at 10:45 a.m. that he believed the death was non-suspicious, before a cause of death had been identified and despite information about witnesses observing fighting at the location the previous evening; and,
    - Thunder Bay Police Service policy required sudden or unexplained deaths to be considered potential homicides, and to be investigated in conformity with the Criminal Investigation Management Plan, which was not done.
- Media:
    - The same-day media release indicating that the death was not suspicious was made too early to draw such a conclusion;
    - The second media release indicating the death was non-criminal was made before the cause of death had been established; and,
    - The media response should have been treated in compliance with the media policy required for a "serious criminal matter."
- Next of kin notification and liaison:
    - When notifying the common-law spouse of Stacey DeBungee's death, officers learned that there were witnesses to Stacey DeBungee's movement the night before;
    - Proper statements were not taken from the witnesses;
    - The Thunder Bay Police Service's sudden death policy required the next of kin to be advised that the nature of the death could not be determined until after an investigation, including the report by the coroner, yet next of kin were notified that the death was non-suspicious;
    - The investigators were not required to meet with the private investigator, but would have received valuable information, if they had done so, relating to the use of Stacey DeBungee's bank card after death;
    - Even though the Thunder Bay Police Service was aware that family members were unhappy with the steps taken by it, the investigators did not advance the investigation until March 2016; and,

- A recommendation was made that a victim liaison officer should have been assigned to communicate with the family.

- Exhibits:
  - Forensic examination was not conducted on any of the exhibits; and,
  - The exhibits were not all retained until the post-mortem examination was released and examined in conjunction with a thorough investigation.
- Witness interviews:
  - Numerous witnesses who had been identified were not interviewed until after the investigation was re-initiated in March 2016.
- Financial records
  - Financial records were not requested until November 22, 2016.

By failing to speak with private investigator David Perry, Staff Sergeant Harrison committed neglect of duty.

As noted, the Agreed Statement of Facts was accompanied by the prosecution's Book of Documents marked as Exhibits #5, #6, and #7. The following is an index listing the material contained therein:

Tab 1	Mr. Simon Butler's OIPRD interview transcript November 9, 2016
Tab 2	Constable Lorentz notebook entries October 19, 2015
Tab 3	Constable Lorentz Supplementary Occurrence Report October 19, 2015
Tab4	Constable Lorentz OIPRD interview transcript December 1, 2016
Tab 5	Constable Bernst notebook entries October 19, 2015
Tab 6	Constable Bernst OIPRD interview transcript December 1, 2016
Tab 7	Detective Constable Tackney Supplementary Occurrence Report October 19, 2015
Tab 8	Detective Constable Tackney notebook entries October 19, 2015
Tab 9	Detective Constable Primmer Supplementary Occurrence Report October 19, 2015
Tab 10	Detective Constable Primmer OIPRD interview transcript December 1, 2016
Tab 11	Detective Constable Tackney OIPRD interview transcript December 1, 2016
Tab 12	Acting Sergeant Dunning OIPRD interview transcript January 18, 2017
Tab 13	Staff Sergeant Harrison notebook entries October 19, 2015
Tab 14	Homicide/Sudden Death Report authored by Constable Verescak October 19, 2015
Tab 15	Constable Verescak notebook entries October 19, 2015
Tab 16	Constable Verescak OIPRD interview transcript December 1, 2016
Tab 17	Dr. Michael Scott OIPRD interview transcript
Tab 18	Chris Adams e-mail correspondence to Staff Sergeant Harrison detailing media statement October 19, 2015
Tab 19	Thunder Bay Police Service Policy Part 2, Chapter 12, Media Relations November 26, 2014

Tab 20 Chris Adams OIPRD interview transcript February 9, 2017
Tab 21 Missing Person Report by Constable Lewkoski October 19, 2015
Tab 22 Constable Lewkoski OIPRD interview transcript November 10, 2016
Tab 23 Detective Constable McKever Supplementary Occurrence Report October 19, 2015
Tab 24 Detective Constable McKever notebook entries October 19-20, 2015
Tab 25 Detective Constable McKever OIPRD interview transcript December 2, 2016
Tab 26 Thunder Bay Police Service Media Release October 20, 2015
Tab 27 Sergeant Whipple OIPRD interview transcript January 11, 2017
Tab 28 Detective Constable McKever notebook entries October 20, 2015
Tab 29 Detective Constable McKever Supplementary Occurrence Report October 20, 2015
Tab 30 Staff Sergeant Kaucharik OIPRD interview transcript January 13, 2017
Tab 31 Staff Sergeant Kaucharik notebook entries October 20, 2015, to August 10, 2016
Tab 32 David Sapay Witness Statement March 28, 2016
Tab 33 Constable Cattani Supplementary Occurrence Report October 21, 2015
Tab 34 Constable Cattani OIPRD interview transcript November 11, 2016
Tab 35 Constable M. Biloski OIPRD interview transcript November 11, 2016
Tab 36 Detective Constable Lepere OIPRD interview transcript November 10, 2016
Tab 37 Detective Constable Lepere Supplementary Occurrence Report October 22, 2015
Tab 38 Postmortem Examination Report by Coroner Dr. Michael Scott October 21, 2015
Tab 39 Staff Sergeant Harrison OIPRD interview transcript January 11, 2017
Tab 40 Thunder Bay Police Service policy Part 6, Chapter 12, Sudden Deaths June 5, 2014
Tab 41 Thunder Bay Police Service policy Part 6, Chapter 105, Criminal Investigation Management Plan January 25, 2013
Tab 42 Ontario Major Case Management Manual October 1, 2004,
A. “Appendix A” - Investigative Functions Responsibilities (removed/ vetted out – postdated the offence date)
Tab 43 Investigative Solution Network Inc. Sudden Death Investigation Report
Tab 44 David Perry OIPRD interview transcript May 29, 2017
Tab 45 Staff Sergeant Harrison notebook entries October 19, 2015, to March 29, 2016
Tab 46 Staff Sergeant Harrison Supplementary Occurrence Report March 29, 2016
Tab 47 Detective Bystrican notebook entries October 19, 2015, and May 12, 2016
Tab 48 Detective Bystrican OIPRD interview transcript January 13, 2017
Tab 49 Constable Kerr OIPRD interview transcript November 10, 2016
Tab 50 Constable Carlucci OIPRD interview transcript November 10, 2016
Tab 51 Brad DeBungee and Chief Jim Leonard OIPRD complaints March 18, 2016
Tab 52 Detective Constable K. Biloski OIPRD interview transcript November 10, 2016
Tab 53 Detective Constable K. Biloski Supplementary Occurrence Report August 10,

2016

Tab 54 Deputy Chief Andy Hay OIPRD interview transcript December 20, 2016

Tab 55 Detective Sergeant Wowchuk OIPRD interview transcript January 13, 2017

Tab 56 Detective Sergeant Wowchuk Supplementary Occurrence Report October 26, 2016 – November 11, 2016

Tab 57 Detective Wowchuk notebook entries October 27, 2016, to November 7, 2016

Tab 58 Detective Constable K. Biloski notebook entries August 10, 2016, to November 7, 2016

Tab 59 Detective Constable K. Biloski Supplementary Occurrence Reports August 31, 2016, to November 24, 2016

Tab 60 Inspector Levesque OIPRD interview transcript January 11, 2017

Tab 61 Ontario Provincial Police Criminal Investigation Branch Review of the Police Investigation into the Death of Stacey DeBungee

Tab 62 Sergeant Whipple notebook entries October 19, 2015 – March 28, 2016

Tab 63 Sergeant Whipple Supplementary Occurrence Reports - Mar 28, 2016, March 28, 2016

Exhibit #7A

Tab 64 Broken Trust: Indigenous People and the Thunder Bay Police Service – Office of the Independent Police Review Director December 2018

Exhibit #7B

Tab 65 Thunder Bay Police Service Investigation Final Report – Senator M. Sinclair November 1, 2018

As noted earlier, the reports found at tabs 64 and 65 and marked as Exhibits 7A and 7B respectively, are not included in the material supporting the Agreed Statement of Facts. Found at tab 64, is a 206-page report titled, Broken Trust: Indigenous People and the Thunder Bay Police Service. The report was completed by Gerry McNeilly of the OIPRD, dated December 2018. There was lengthy discussion about how this exhibit ought to be viewed by the tribunal. Ms. James and Mr. Dubois took the position that the Broken Trust Report ought to be accepted just as the previous 63 tabbed material was accepted: for the truth of its content. In lieu, Ms. James sought to have Mr. McNeilly called as a witness at this hearing to allow defence counsel an opportunity to cross examine Mr. McNeilly on any aspect of the report and/or the investigation, such as but not limited to, the scope of the investigation, the findings, recommendations, and conclusion.

Ms. James noted that the Broken Trust Report flowed from the complaint. The complainants requested an investigation into alleged police misconduct, but also sought to have a systemic review undertaken because the alleged misconduct was emblematic of a poisoned work environment within the Thunder Bay Police Service due to racism. Ms. James and Mr. Dubois submitted the Broken Trust report ought to be before the tribunal for more than simply persuasive argument, it ought to be before the tribunal for the truth of its content.

Mr. Butt submitted that he took no issue with the report being properly before the tribunal and took no issue with the fact that it contains conclusions pertaining to the systemic review of the Thunder Bay Police Service. Mr. Butt submitted the documents can be properly used to drive conclusions in the sense that they can be persuasive, but submitted I must decide how those conclusions affect the evidence before this tribunal. Mr. Butt indicated that if Mr. McNeilly was before the tribunal as a witness, he would have no questions to pose to him.

I determined there would be no need to hear from Mr. McNeilly directly, the Broken Trust report was properly before me as a marked exhibit and it could be relied upon for the purpose of suggesting that because systemic racism exists in the Thunder Bay Police Service, I am capable of inferring that systemic racism played an important role in the officer's conduct.

NOTE: The Broken Trust report included findings specific to the Stacey DeBungee death investigation. Counsel agreed that element of the report ought not to be before the tribunal. Consequently, pages 128 to the top of page 138 are considered vetted out, along with pages 182 to the top of page 184. These sections are also referred to as pages 1315 – 1325 and 1369 – 1371 in the prosecution's Book of Records.

The report found at tab 65 is the Thunder Bay Police Service Investigation Final Report drafted by Senator M. Sinclair November 1, 2018. This document will be viewed in similar light to the Broken Trust report, not accepted necessarily for the truth if its consequences, but to provide guidance to the tribunal related to the state of policing in Thunder Bay at the time of the report. The Broken Trust report and the Sinclair report will be referred to in greater detail later in this decision.

Testimony

The prosecution called nine witnesses: Retired Deputy Chief of Police Andrew Hay; Sergeant Clark McKever (assigned to the Criminal Investigation Branch at the time, actively participated in the sudden death investigation); Detective Shannon Primmer (assigned to the Forensic Identification Unit at the time - actively participated in the sudden death investigation); Public Complainant James Leonard, former Chief of the Rainy River First Nation; Constable Janine Lewkoski (received and submitted the Stacey DeBungee missing person report); Chris Adams, Director of Communications and Technology, Thunder Bay Police Service, (drafted and disseminated the two media releases associated to the sudden death investigation); retired Staff Sergeant Susan Kaucharik (assigned to the Criminal Investigation Branch at the time as Staff Sergeant Harrison's supervisor); Public Complainant Brad DeBungee; and Private Investigator David Perry.

The defence called two witnesses, Staff Sergeant Harrison and Detective Whipple who testified in their own defence. The following is a summary of the testimony heard:

Deputy Chief (ret.) Andrew Hay – Examination-in-Chief

Deputy Hay retired from the Thunder Bay Police Service in 2016. During his 32-year career, he gained experience investigating death and homicide cases. Mr. Dubois noted the areas in the Agreed Statement of Facts that relate to Deputy Hay's evidence. In 2015 – 2016 Deputy Hay's responsibilities included overseeing operations and administration of the police service. He supervised the inspector of the Criminal Investigation Branch who at the time was Inspector Levesque, but Staff Sergeant Kaucharik acted on his behalf regularly due to Inspector Levesque's medical condition at the time.

At tab 14 of Exhibit # 5 is a copy of the Sudden Death Report authored by Constable Verescak and dated October 19, 2015. Deputy Hay testified that he would have expected Staff Sergeant Harrison, as the lead investigator, to have reviewed that report.

At tab 23 of Exhibit #5 is Detective Constable McKever's Supplementary Occurrence Report dated October 19, 2015. Deputy Hay testified that he would have expected Staff Sergeant Harrison, as the lead investigator, to have reviewed the supplementary report.

At tab 33 of Exhibit #5 is Constable Cattani's Supplementary Occurrence Report dated October 21, 2015. Deputy Hay testified that he would have expected Staff Sergeant Harrison, as the lead investigator, to have reviewed that supplementary report.

Deputy Hay testified that his expectation was not Niche RMS driven (administrative report checking), it was a general expectation that all reports related to the sudden death investigation would be reviewed by the investigating officer. Deputy Hay stated that he would have also expected that Sergeant Whipple would have seen the reports at some point, but it would have been incumbent upon Staff Sergeant Harrison as the lead investigator to review the reports.

At tab 40 of Exhibit #6 is the Thunder Bay Police Service policy titled, Part 6, Chapter 12, Sudden Deaths, dated June 5, 2014. At tab 41 is the Thunder Bay Police Service policy titled, Part 6, Chapter 105, Criminal Investigation Management Plan, dated January 25, 2013.

Deputy Hay testified that in his capacity as Deputy Chief, he was familiar with policy and the documents which would have provided guidelines to the Criminal Investigation Branch pertaining to death investigations.

Deputy Hay testified that in this instance, the cause of death was unknown from the commencement of the investigation. Consequently, the officers ought to have known that they may have been dealing with a homicide even if it did not look so initially. He stated that policy indicates the investigation needs to be treated criminally because it could ultimately evolve into a homicide investigation.

At tab 42 of Exhibit #6 is the Ontario Major Case Management Manual (the attached Appendix titled “Investigative Functions Responsibilities” is dated after the alleged misconduct in this matter and therefore, was not utilized or relied upon). Deputy Hay stated that if the Criminal Investigation Branch was dealing with a potential homicide, it could meet the definition of a major case as per the Major Case Management manual. Deputy Hay stated that given the circumstances in this case, the investigators should have considered the death a potential homicide early on in the investigation. Deputy Hay stated the investigators ought to have been guided by the Criminal Investigation Management Plan as the death had potential to evolve into a major case as defined; it was to be treated as a suspicious death.

<u>Deputy Chief (ret.) Andrew Hay – Cross Examination – Ms. James</u>

Deputy Hay stated that there remained investigative steps to be completed such as having the witness Michael Chartier formally interviewed as the altercation between two males the previous day would have been concerning. Deputy Hay testified that the sudden death should have been treated as a homicide initially to ensure that all relevant evidence and information was collected and preserved.

Deputy Hay testified at the Inquest into the Deaths of Seven First Nations. He acknowledged that one of the concerns raised was that the Thunder Bay Police Service had made premature conclusions about the manners of death and the Thunder Bay Police Service was aware this was a community held concern. Deputy Hay stated that although prematurely worded media releases were not isolated incidents, he was not prepared to concede it was a regular occurrence.

At tab 18 of Exhibit #5 is an email dated October 19, 2015, 12:34 p.m. from Chris Adams addressed to Staff Sergeant Harrison and copied to Detective Lou Bystrican, Inspector Levesque and Staff Sergeant Kaucharik. It reads as follows:

> Shawn: As per our conversation, this is the media release that will be going out. Chris.
>
> Death Investigation – The Thunder Bay Police are investigating the death of an adult male. A passerby saw a body in the McIntyre River in the area of Carrick and Waterford Streets just before 9:30 this morning and called 9-1-1.

> 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.

Deputy Hay testified that in his opinion, the media release was inaccurate, the death was still considered suspicious; he could not explain why the release was drafted using this language. He explained that the media officer cannot publish a media release without approval from the investigating officer and in this case, he would have expected Staff Sergeant Harrison to recognize the information in the media release was not accurate based on information that was known at the time.

Deputy Hay testified that he learned of David Perry's investigative report in the spring of 2016, after the OIPRD complaint had been filed. Deputy Hay stated he would have expected the investigators to avail themselves to Stacey DeBungee's family if they had concerns about the manner of his death. Deputy Hay also noted that Stacey DeBungee's debit card being utilized following his death would have been relevant to the investigation.

Deputy Hay testified that he had not read the report stemming from the Inquest into the Deaths of Seven First Nations as he had retired prior to its release, but he was aware that the Thunder Bay Police Service acknowledged that systemic racism existed within, and he agreed with that finding. He noted that he did not personally observe direct racism within the police service during his tenure; if he had seen anything overtly racist, he would have acted on it accordingly.

Deputy Hay stated that systemic racism is entrenched in society and the Thunder Bay Police Service was no exception, the service did not reflect the community they served and there was not enough consultation with the Indigenous community; consequently, the community became alienated and their confidence in police was undermined. He acknowledged that premature media releases would contribute to undermining public confidence.

<u>Deputy Chief (ret.) Andrew Hay – Cross Examination – Mr. Butt</u>

Deputy Hay agreed that as an executive who has wrestled with these issues for years, he understands the distinction between systemic and overt racism by individuals. Deputy Hay indicated he had no contact with Staff Sergeant Harrison or Sergeant Whipple during the investigation but in the broader sense, he knew them to be exemplary officers. He had confidence in their ability as investigators and had never seen them partake in jokes or take part in racist behaviour.

Deputy Hay agreed that he would be concerned about people within the Thunder Bay Police Service getting promoted with racist attributes. He did not object to Staff Sergeant Harrison being promoted prior to his retirement.

Deputy Hay testified that if other officers had any difficulty with the media release as noted in the email dissemination list, they should have come forward with those concerns. He acknowledged the media release stated it was only the initial investigation and that a post-mortem was pending which could be interpreted as the investigation was in its initial stage and the officers' minds remained open. He agreed that the fact that the deceased had not yet been identified also suggested it was early in the investigation.

Deputy Hay testified that the evidence commenced in early October 2015 at the Inquest into the Deaths of Seven First Nations and the subsequent report was released in the spring, or June of 2016. He stated that there were about 145 recommendations, eight of which pertained to the Thunder Bay Police Service, none of which had anything to do with premature press releases.

Deputy Hay stated that while evidence was being heard at the inquest in October 2015, no one was reporting the results back to front line officers. Senior Command was briefed and if issues were raised that required immediate attention, they would have dealt with it immediately rather than waiting for recommendations.

Sergeant Clark McKever – Examination-in-Chief

At the time of this incident, Sergeant McKever was a detective constable assigned to the Criminal Investigation Branch on a team with Sergeant Whipple and Staff Sergeant Harrison. Mr. Dubois reviewed the aspects of the Agreed Statement of Facts pertaining to Sergeant McKever's involvement in this matter.

On October 19, 2015, Sergeant McKever attended the scene of the sudden death and later, attended the residence of Evelyn Kwandibens, for next of kin notification along with Sergeant Whipple. Sergeant McKever stated he met with several people in the living room while Sergeant Whipple remained in the doorway area. He stated there was a commotion that was occurring in the hallway or in another apartment that Sergeant Whipple was dealing with. Sergeant McKever stated he was taking the lead, doing most of the communicating while Sergeant Whipple came in and out the apartment. Sergeant McKever testified that after the meeting, he and Sergeant Whipple would have discussed what was said at the meeting, but he could not recall that specific conversation.

Sergeant McKever stated that it was just implied that he would complete the Supplementary Occurrence Report because he was the one who had conversed with those present in the apartment. He said Sergeant Whipple would have been aware of what had happened at the apartment, but he may not have reviewed the report.

Sergeant McKever stated that at the next of kin meeting, he learned that David Sapay was the last person to see Stacey DeBungee. The next day he and Sergeant Whipple went looking for Mr. Sapay to question him about the incident and to learn anything ese that would have helped the investigation.

Sergeant McKever had no actual recollection of it happening, but said Sergeant Whipple and Staff Sergeant Harrison would have been informed of the conversation which unfolded at the next of kin meting including the personal identification found at the scene.

Sergeant Clark McKever – Cross Examination – Ms. James

Sergeant McKever stated that when he attended the scene, he assisted in removing Stacey DeBungee's body from the water. Sergeant McKever stated that once the body was turned over, from face down to face up, another officer said they thought it was Stacey DeBungee and he also believed there to be a resemblance.

Sergeant McKever indicated he had dealt with Stacey DeBungee on previous occasions. He recalled that about one year prior, Stacey DeBungee was laying in a parking lot, too intoxicated to care for himself. Sergeant McKever stated he was uncertain if he informed the other officers at the scene of this previous contact. The recollection was not recorded in his notebook, he said it was not necessarily noteworthy at the time of the death investigation.

Sergeant McKever was uncertain as to whether there was a conversation at the scene about theories as to what may have possibly happened to Stacey DeBungee. He said it is natural to discuss working theories as avenues of possibilities. Sergeant McKever noted that there was no sign of trauma and agreed that a lack of visible injury does not mean that a criminal offence had not occurred, further investigation would be warranted.

Sergeant McKever stated he was unaware at the time that a person had said two Indigenous males had been drinking at the water and had been involved in an altercation. He testified that it would have been included in his notes had he known. Sergeant McKever stated that knowing that information would not have elevated the matter to one of a suspicious death unless the altercation was linked to the death. Sergeant McKever stated he considered the matter an undetermined death at the time.

Sergeant Clark McKever – Cross Examination – Mr. Butt

Sergeant McKever testified that the Criminal Investigation Branch at the time was very busy, the officers were constantly overwhelmed with work. He noted that at the time, there was not a separate homicide unit, the Criminal Investigation Branch investigated all serious matters,

homicides, sexual assaults, assaults, robberies, etcetera. Sergeant McKever testified that the victims in those matters were of Indigenous descent more often than not.

Sergeant McKever stated that in his six years in the Criminal Investigation Branch, he never witnessed an officer give less than full effort due to cultural background, it had no bearing on an investigation.

Sergeant McKever testified that officer assignments in the Criminal Investigation Branch were more organic, everyone just filled in the gaps as needed, everyone knew their roles and did what needed to be done.

Sergeant McKever stated there was an outstanding arrest warrant for David Sapay. Mr. Sapay had court ordered conditions to reside at a specific residence. Sergeant McKever and Sergeant Whipple attended that residence the following day. He noted that it is more challenging to locate witnesses who do not wish to be found. They learned Mr. Sapay was no longer staying at the residence as indicated in the Supplementary Occurrence Report that he completed.

Sergeant McKever testified a MOB is an acronym for “Major Occurrence Bulletin.” A MOB contains information which is read out at every uniform shift briefing. BOLO is an acronym for “Be On the Look Out” which notifies an officer of information related to an individual when they are checked on the police database. Sergeant McKever stated Mr. Sapay was placed on a MOB and BOLO, indicating that he was to be contacted when Mr. Sapay was located but that never occurred. He took no further steps to locate Mr. Sapay.

<u>Detective Shannon Primmer – Examination-in-Chief</u>

Mr. Dubois reviewed the areas from the Agreed Statement of Facts that relate to Detective Primmer’s evidence.

<u>Detective Shannon Primmer – Cross Examination – Ms. James</u>

At the time of this matter, Detective Primmer was a detective constable in the Forensic Identification Unit. She stated that she would have been dispatched to attend the scene and told that there was a body found in the river. Detective Primmer stated she was familiar with the sudden death investigation policy which reads:

> Investigations into sudden or unexplained deaths and found human remains be considered potential homicides and be undertaken in accordance with the police service’s Criminal Investigation Management Plan.

Detective Primmer testified this did not mean to her that the matter was to be treated as a homicide, she stated that every incident is different depending on the circumstances and treated accordingly. In this instance, the body was still in the water upon her arrival, she had no knowledge as to how it got there. She agreed that she was responsible for surveying the scene and collecting evidence.

Detective Primmer testified that she was responsible for photographing evidence at the scene. She did not record video, indicating video recordings are generally reserved for homicide investigations or major cases. She could not recall if there was a conversation with members of the Criminal Investigation Branch about recording the scene on video. She stated there was consultation with the coroner, but she could not recall the details, she believed she was told there were no injuries to indicate it was a homicide. Detective Primmer agreed that obvious trauma is not the only indicator of a suspicious death and agreed that at the scene, they did not know how Stacey DeBungee died.

It was suggested to Detective Primmer that she was informed that the Stacey DeBungee death was nonsuspicious which is why she did not focus on the body when taking photographs at the scene. Detective Primmer testified that ordinarily, photographs of the deceased person are taken at the post-mortem. Detective Primmer stated that the scene was next to a bike path, therefore, not all cigarette butts in the area were seized. She agreed that the one cigarette butt found next to the body should have been seized but was not.

Detective Primmer acknowledged measurements at the scene were not recorded but could offer no rationale other than perhaps inexperience. Detective Primmer had been in the Forensic Identification Unit since 2011 but could not recall personally dealing with a body found in the river prior to this incident.

Detective Primmer could not recall who decided to release the scene but she was certain it was not her decision. She stated there would have been a conversation with the detectives and with the coroner. She was aware that a post-mortem was scheduled. Detective Primmer did not recall a conversation as to how Stacey DeBungee ended up in the river, she was unable to provide evidence as to what made the death nonsuspicious other than the lack of obvious trauma to the body.

Detective Primmer denied the assertion that the police responded in the manner they did because they assumed Stacey DeBungee was “just another drunken Indigenous person who rolled into the river and drowned.”

Detective Shannon Primmer – Cross Examination – Mr. Butt

Detective Primmer stated that she did not recall Staff Sergeant Harrison being at the scene. While at the scene, she recalled that someone stated that the deceased person was Stacey DeBungee, not David Sapay. Detective Primmer did not recall any officer treating this call for service in a cavalier or disrespectful manner.

Detective Primmer acknowledged that Forensic Identification Unit officers receive specialized training specific to scene management and processing. Detective Primmer stated that as a Forensic Identification officer, she has an expertise that is relied upon by other officers at police scenes. Detective Primmer agreed there is an efficient division of labour at scenes, detectives have their jobs, and she focusses on the collection of evidence. This scene was no different, she was allowed to focus on her area of expertise.

Detective Shannon Primmer – Re-examination

At tab 3 of Exhibit #5 is a Supplementary Occurrence Report submitted by Constable Lorentz on October 19, 2015, which in part, reads as follows:

> At approximately 11:45 hours, Constable Lorentz and Constable Bernst departed the scene, as Criminal Investigation Branch officers, as well as the coroner, advised that there was no reason to hold the crime scene anymore.

Detective Primmer indicated that releasing the scene is synonymous with no longer holding the scene.

James Leonard – Examination-in-Chief

At the time of this incident, James Leonard was the Rainey River First Nations Chief. His complaint can be found at tab 51 of Exhibit # 6. Mr. Dubois reviewed the sections found in the Agreed Statement of Facts pertinent to Mr. Leonard's evidence.

Mr. Leonard stated he filed the complaint after being approached by Stacey DeBungee's family. He noted that they expressed frustration about not getting questions answered by the Thunder Bay Police Service and held concern about the media reporting the death being nonsuspicious in a matter of hours after the body had been discovered.

James Leonard – Cross Examination – Ms. James

Mr. Leonard first heard about the death of Stacey DeBungee by reading about it in the newspaper. He was concerned that another Indigenous person had been located deceased in the river.

Mr. Leonard knew the Inquest into the Deaths of Seven First Nations had commenced and he was immediately struck that this investigation was being treated similarly by the police; immediately dismissing the matter as that of nonsuspicious. Mr. Leonard testified that the Treaty Three Police Service routinely secures the scene of a death until post-mortem results have been obtained by the coroner and police. The fact that the Thunder Bay Police Service did not secure this scene was an issue being discussed by Indigenous leadership.

Mr. Leonard stated that the findings of Mr. Perry reinforced community concerns that the poor investigation into the death of Stacey DeBungee conducted by the officers was directly attributed to racism.

James Leonard – Cross Examination – Mr. Butt

Mr. Leonard confirmed that he had never met or had personal interaction with Staff Sergeant Harrison or Sergeant Whipple.

Janine Lewkoski – Examination-in-Chief

Janine Lewkoski retired from the Thunder Bay Police Service in 2021. At the time of this incident, Constable Lewkoski was working as a resource officer. Mr. Dubois reviewed the pertinent sections of the Agreed Statement of Facts relating to Constable Lewkoski's evidence.

Janine Lewkoski – Cross Examination – Ms. James

On October 19, 2015, Constable Lewkoski submitted a missing person report found at tab 21 of Exhibit #5. Cornelius Wapoose and Evelyn Kwandibens reported Stacey DeBungee missing and were concerned that he might be the person found in the river that morning.

Constable Lewkoski was aware that a body had been recovered in the river but was not certain if there was a connection, so she filed the information under a missing person report.

Constable Lewkoski was familiar with Stacey DeBungee, she had dealt with him professionally at a time when he was intoxicated, and she knew him because he frequented a bar owned by her sister.

In response to being asked about her perspective of the relationship between the Thunder Bay Police Service and the Indigenous community, Constable Lewkoski stated there has always been a difference of opinion and the relationship appears further stressed now than even one year earlier. Constable Lewkoski opined that some Indigenous people and some police officers are racist. She stated that everyone should be respectful but that is not always the case.

Constable Lewkoski took exception to the media reporting that all members of the Thunder Bay Police Service were racist. She acknowledged officers had made “stupid comments” without having all the facts. Constable Lewkoski stated Staff Sergeant Harrison had been her direct supervisor, and less frequently, so had Sergeant Whipple; she had never heard Staff Sergeant Harrison or Sergeant Whipple make a racist comment.

Janine Lewkoski – Cross Examination – Mr. Butt

Constable Lewkoski testified she was always impressed with the professionalism and decision making demonstrated by Staff Sergeant Harrison; she often went to him for guidance if she encountered difficulty related to calls for service.

Chris Adams – Examination-in-Chief

Chris Adams is the Director of Communications & Technology at the Thunder Bay Police Service. At the time of this incident, he was the Executive Officer and his responsibilities included oversight of corporate communications including media relations. Mr. Adams had a media relations constable who reported to him. Mr. Dubois reviewed the relevant sections of the Agreed Statement of Facts as they relate to the evidence of Mr. Adams.

Chris Adams – Cross Examination – Ms. James

Mr. Adams confirmed that although he is considered senior management within the Thunder Bay Police Service, his role is that of a civilian position. Mr. Adams was aware that the Inquest into the Deaths of Seven First Nations had commenced October 5, 2015, and he was aware of the type of evidence emanating from it as he was dealing with media inquiries. He did not recall if one of the issues identified was the premature classification of deaths before a post-mortem had been conducted but agreed it could have been raised.

Mr. Adams testified that the first media release in this matter would have been based on conversations he had with Staff Sergeant Harrison at the scene. He stated the media release would have wanted to inform the community whether there was an imminent threat to public safety; the scene was near a well used recreational trail and the police were obligated to issue a public warning if such a concern existed.

In the initial media release, Mr. Adams stated that their intent was to indicate the evidence at the time did not suggest that the death occurred as a result of a homicide. Mr. Adams stated that based on a brief discussion with Staff Sergeant Harrison, he knew there was nothing indicating foul play. He was not aware of what evidence was known to the investigators; the conversation with Staff Sergeant Harrison would have been at a higher level.

Mr. Adams stated that the purpose of the second media release was to indicate the investigation was of a non-criminal nature. He stated that the information would have come from the people directly involved in the investigation, but he could not recall who authorized the second media release.

Mr. Adams stated that since 2015, the manner in which the Thunder Bay Police Service deal with media releases has evolved, information they contain has been tightened and complete accuracy is ensured. Also, they are certain to have a record of the approval process for all media releases.

Mr. Adams testified that the initial media release in this instance was insensitive, and the message conveyed was too conclusive that the death was nonsuspicious. Mr. Adams agreed that the media release could have caused mistrust amongst the family because it suggested a very early cause of death determination.

Chris Adams – Cross Examination – Mr. Butt

Mr. Adams agreed that in the initial media release, it was important to not reveal too much information while at the same time attempting to calm the public so they would not fear a killer was on the loose. Conversely, if there was an imminent threat to public safety, the media release would have needed to convey that; the release was based on the information known at the time.

Mr. Adams agreed that the title on the media release is “death investigation,” and the term “investigating” is found in the first sentence, both suggest there had been no conclusions drawn, that the investigation was ongoing. Mr. Adams confirmed the media release was copied to Staff Sergeant Kaucharik and to Inspector Levesque, it was his usual practice to involve the chain of command in the approval process. He confirmed that no one, including Staff Sergeant Kaucharik nor Inspector Levesque, told him to not disseminate the release which caused him to believe they were all on board with this release.

Mr. Adams testified there was no information suggesting the investigation was being written off for racist reasons, he had worked with Staff Sergeant Harrison on multiple cases and had found his work ethic, professionalism, and judgement all top rate; improper racist motives would not influence Staff Sergeant Harrison’s judgement.

Chris Adams – Re-examination

Mr. Adams confirmed that he did not know what Staff Sergeant Harrison took into account in deciding that the death was not considered suspicious, and a killer was not on the loose.

Staff Sergeant Susan Kaucharik – Examination-in-Chief

Staff Sergeant Kaucharik retired from the Thunder Bay Police Service in April 2022. In October 2015, she was the staff sergeant in the Criminal Investigation Branch, but frequently, was also the acting inspector as a result of Inspector Levesque dealing with ongoing medical issues. Mr. Dubois reviewed the relevant areas of the Agreed Statement of Facts specific to the evidence of Staff Sergeant Kaucharik.

On October 19, 2015, Staff Sergeant Kaucharik was in training, consequently Sergeant Bystrican was acting as staff sergeant on her behalf. Staff Sergeant Kaucharik believed she was notified of the Stacey DeBungee death investigation on October 20, 2015, by either Sergeant Bystrican or Staff Sergeant Harrison. On that date, Staff Sergeant Kaucharik took a phone call from the Deputy Grand Chief of Nishnawbe Aski Nation. She advised her the Stacey DeBungee death did not appear to be criminal in nature at that time. Staff Sergeant Kaucharik testified that she did not recall who she received that information from. She was reminded that in her interview with the OIPRD, she indicated she received that information from Staff Sergeant Harrison. Staff Sergeant Kaucharik testified she could not recall that interview and could not recall who provided her this information about the death being nonsuspicious.

Staff Sergeant Kaucharik testified that she was unaware if the next of kin had been notified by the time, she had conversed with the Deputy Grand Chief. Staff Sergeant Kaucharik stated the scene would not have been released if there was any concern it was a criminal matter which would have been standard practice. Staff Sergeant Kaucharik testified the coroner would ask the scene to be held by police if he had concerns. She noted that releasing the scene is the coroner's decision.

Staff Sergeant Kaucharik acknowledged she was copied on Mr. Adams' email regarding the initial media release, but she probably would not have looked at it until the following day considering her training commitment. Staff Sergeant Kaucharik stated that generally, the inspector or staff sergeant would be consulted prior to a media release but not always.

Staff Sergeant Kaucharik stated that after speaking with the Deputy Grand Chief, she confirmed that the next of kin had been notified and she informed Mr. Adams that the name of the deceased could be released to the public. She stated she did not see the draft of the second media release, nor did she recall approving it.

Staff Sergeant Kaucharik testified that she did not have much of a role in the investigation between the date of the incident and March 2016. She spoke with the Deputy Grand Chief on October 20, 2015, was on training the following day, and then off from work for the next week. She stated that upon her return to the office, the matter was off her radar. Staff Sergeant Kaucharik had heard the officers were looking for an individual, so she asked them to add him

to BOLO. Later, she learned the individual had been in custody twice and the officers had not been notified so she amended the manner in which the name had been added to the records management system to rectify that error. She had no further involvement.

Susan Kaucharik – Cross Examination – Ms. James

Staff Sergeant Kaucharik stated she did not micromanage subordinates, her role was more administrative. She stated that sudden deaths were not treated as major cases unless the death was suspicious in nature.

Staff Sergeant Kaucharik testified that Staff Sergeant Harrison and Sergeant Whipple were excellent investigators having the necessary skill and experience to conduct thorough investigations, she did not expect them to report to her on a daily basis. Staff Sergeant Kaucharik acknowledged that the media release classified the death as non-criminal prior to the post-mortem, but the death was not classified as such by the police until afterwards. She stated that if something had come up in the post-mortem examination that made the officers to become suspicious, the investigation would have been handled as a major case. Staff Sergeant Kaucharik agreed that on October 20, 2015, the matter was deemed nonsuspicious because there was no evidence of foul play. Staff Sergeant Kaucharik agreed it is incumbent upon the police to investigate to determine if foul play exists.

Staff Sergeant Kaucharik denied the assertion that people drinking in the area of the scene the previous day, an altercation, identification found at the scene not belonging to the deceased and no information indicating how the body entered the river amounted to suspicion of foul play.

Staff Sergeant Kaucharik testified it would have been her expectation that the investigating officers followed up on the altercation information. Staff Sergeant Kaucharik agreed that a post-mortem report can provide the cause of death and can at times, provide the manner of death but usually that is determined by investigative steps conducted by police. She stated that the post-mortem was conducted on October 21, 2015, but she did not review it because she was off work for the following week. In this instance, the report indicated that the cause of death was freshwater drowning, but the coroner would not be able to speak to how Stacey DeBungee got into the water. Staff Sergeant Kaucharik agreed that if he was dragged into the water for example, that would elevate the investigation to one of a criminal matter.

Staff Sergeant Kaucharik testified that Staff Sergeant Harrison would not have required her approval to send out a media release in relation to this investigation.

Ms. James reviewed the investigative steps conducted by Staff Sergeant Harrison, Sergeant Whipple, and Sergeant McKever according to their notebook entries and noted the Forensic

Identification Unit 's involvement ended at the post-mortem. Staff Sergeant Kaucharik stated that some investigative direction may have occurred which was not documented by Staff Sergeant Harrison. She also noted that the Criminal Investigation Branch was always short staffed, and the officers were very busy. Staff Sergeant Kaucharik stated the investigators would have done a through investigation to the best of their ability with the time that they had.

Susan Kaucharik – Cross Examination – Mr. Butt

Staff Sergeant Kaucharik explained that the BOLO alert was flagged to the incident, not to the name of David Sapay which is why the investigators were not notified when police members dealt with him before the BOLO was amended. Staff Sergeant Kaucharik stated she did not know the totality of the information the investigators were operating under, so she was unable to comment about her expectations other than she expected them to make proper decisions.

Staff Sergeant Kaucharik stated that she had worked with Staff Sergeant Harrison prior to him coming into the Criminal Investigation Branch and his behaviour was always exemplary, in fact she recruited him into the office. As his supervisor, she was happy with his work, he was a good supervisor and leader. Staff Sergeant Kaucharik stated Sergeant Whipple conducted excellent investigations as a member of the Criminal Investigation Branch.

Staff Sergeant Kaucharik testified that she never saw any indication from either officer in terms of racist behaviour, she never observed them doing less than their best because of the cultural background of a victim. Staff Sergeant Kaucharik was never aware of there being evidence that someone was dragged into the river in this case.

Staff Sergeant Kaucharik agreed that an officer assuming a crime had been committed could lead to negative consequences. She agreed police cannot jump to conclusions in the absence of evidence, officers must rely on the evidence presented. Staff Sergeant Kaucharik agreed that the information related to the altercation would have been relevant if the parties could have been identified. Staff Sergeant Kaucharik agreed that no visible signs of trauma suggested Stacey DeBungee was not involved in a physical altercation.

Susan Kaucharik – Re-examination

In response to being asked how the officers would have known that there was no killer at large just three hours into an investigation resulting in the initial media release, Staff Sergeant Kaucharik stated it would have been based on the information they gathered at the scene in consultation with the coroner. Staff Sergeant Kaucharik confirmed that generally speaking, tunnel vision could also result in concluding no crime has been committed.

Brad DeBungee – Examination-in-Chief

On the afternoon of Tuesday October 20, 2015, Brad DeBungee learned of his brother's death through his spouse, who had received a telephone call from his cousin. Later that evening, he attended the Thunder Bay Police Service, asked to speak with the investigating officer to learn how Stacey ended up in the river. He was told the officer was unavailable, they were to meet the following day.

On Wednesday October 21, 2015, Brad DeBungee, with his aunt Mary and cousin Karen Williams, met with Staff Sergeant Harrison, Sergeant Whipple and a third officer was also present. Brad DeBungee testified that he asked questions and learned Stacey was found by a person walking on the trail. The third officer at the meeting indicated that he went into the river to pull Stacey out of the water. Brad DeBungee was told that the police could not disclose photographs of the scene, but it was their opinion that Stacey had passed out, rolled into the river, and drowned. The police informed him there was a person they were looking to speak with, but he had outstanding warrants and did not want to be found.

Brad DeBungee testified that the police informed him witnesses saw two people passed out on the bank at 8 or 9 p.m. Brad DeBungee testified that to him, "passed out" meant falling asleep because the person is unable to stay awake due to alcohol consumption.

Brad DeBungee was told that the police would contact him if they found new information. He stated that Staff Sergeant Harrison only presented one option, that Stacey passed out, rolled into the river, and drowned. Brad DeBungee asked to see his brother to identify him. He was informed that Stacey had been identified already, he would have to wait for the completion of the post-mortem to view the body which might not be until Friday October 23, 2015.

Brad DeBungee testified that during the meeting, he asked if he was able to get another opinion. Staff Sergeant Harrison suggested that he not do that. Brad DeBungee testified that during the meeting they briefly discussed the Inquest into the Deaths of Seven First Nations.

Following the meeting with police, Brad DeBungee attended the scene. He was surprised that Staff Sergeant Harrison showed up a short time later. Brad DeBungee stated that Staff Sergeant Harrison showed him at that time where Stacey had been located in the water.

Brad DeBungee noted that since 2015, the shoreline of the river is shorter by three or four feet, the bank has receded making it higher, and the weeds that existed at the time are no longer present.

Brad DeBungee stated that later that evening, Staff Sergeant Harrison telephoned him informing him that the post-mortem had been completed and he could collect his brother's body.

Brad DeBungee stated that he sought the assistance from Rainy River First Nation because he was not satisfied with the investigation by the Thunder Bay Police Service. When he viewed his brother's body, the upper left side of Stacey's head was swollen, his nose was twisted, there was a mark on his cheek, and it was puffy.

On November 19, 2015, Brad DeBungee attended the Thunder Bay Police Service with David Perry. They asked to speak with Staff Sergeant Harrison, but he said they were brushed aside by the lady working at the front counter. They left a message to be contacted by Staff Sergeant Harrison but received no call.

On November 24, 2015, Brad DeBungee attended the Thunder Bay Police Service on his own where he conversed with Staff Sergeant Harrison in an interrogation room. Brad DeBungee testified that they talked about seven bodies being found in the river, and Staff Sergeant Harrison bragged about his crime solving rate in spite of an inadequate police budget.

Brad DeBungee testified that he told Staff Sergeant Harrison he was a liar, the evidence in those cases must have been handed to him on a silver platter, he would not have had to work to obtain those results. As he got up to leave Staff Sergeant Harrison initially did not want to shake his hand, but ultimately, he did. Staff Sergeant Harrison told him to obtain a Freedom of Information application from the front counter to obtain any information he sought regarding the sudden death investigation.

Brad DeBungee testified that Staff Sergeant Harrison offered no new information. Staff Sergeant Harrison told him that Stacey had rolled into the water, and drowned. In response to his Freedom of Information request, Brad DeBungee was informed by the Thunder Bay Police Service that no information could be divulged about the investigation because it was still an ongoing file.

<u>Brad DeBungee – Cross Examination – Ms. James</u>

Brad DeBungee stated that in his meetings with Staff Sergeant Harrison, he did not provide any other theory about what happened to Stacey other than the conclusion that he passed out, rolled into the river, and drowned. He stated he was not asked about Stacey's friends, or what he thought may have happened to Stacey.

Brad DeBungee testified that the coroner was unable to tell him how Stacey ended up in the water and offered no theory other than he passed out and rolled into the water. He said the coroner was unable to tell him when Stacey had died, how long he had been in the water, the temperature of the water, or the temperature of Stacey's body. The coroner informed him those measurements were not taken.

Brad DeBungee – Cross Examination – Mr. Butt

Brad DeBungee recalled that Staff Sergeant Harrison told him the toxicology results would take six to nine weeks and recalled him saying the police were in the process of trying to find the person whose identification was located nearby his brother's body. Staff Sergeant Harrison provided Brad DeBungee with his business card and told him to call if he had questions.

David Perry – Examination-in-Chief

Mr. Dubois noted the report completed and filed by Mr. Perry was in evidence and was referenced accordingly in the Agreed Statement of Facts. Mr. Perry reviewed his experience as a criminal investigator with the Toronto Police Service and as a private investigator since his retirement. He is familiar with the Major Case Management Manual, had used it often and trained others in it.

Mr. Perry stated that a situation involving a person found deceased in the water, exhibiting no signs of trauma, with at least one possible witness to be questioned with the post-mortem pending, has the potential to be considered a Major Case as defined in the Manual. Mr. Perry indicated that all missing persons or found human remains, with any hint of suspicion, triggers the implementation of Major Case Management.

Mr. Perry stated that on November 19, 2015, he attended the Thunder Bay Police Service accompanied by Brad DeBungee. Mr. Perry was in possession of information that he wanted to share with the investigators; it was important for them to have it. Brad DeBungee attended the front desk and was told the investigators were not available. Mr. Perry approached and asked to speak with a supervisor. He conversed with Detective Reid, identified himself, his background, and his role. He informed Detective Reid he had information to share, left his card, and asked that he be contacted by the investigators.

Mr. Perry left the station, not expecting to be contacted based on how he and Brad DeBungee were received, and he was correct, he was never contacted by an investigator.

David Perry – Cross Examination – Ms. James

Mr. Perry indicated he has experience investigating sudden deaths as an officer and as a private investigator. He stated that it is important for investigators at the scene of a sudden death to have an open mind, to find out who, what, where, why, how and by what means the death occurred. Mr. Perry discussed the importance of setting up a perimeter to protect a crime scene.

Upon reviewing the information at the commencement of this investigation, Mr. Perry was concerned that the police had disseminated a media release so early into the investigation announcing that the death was non-criminal with no foul play. He questioned how that could be determined unless there was an eyewitness who viewed a suicide for example.

Mr. Perry explained that he had no difficulty contacting witnesses during the few days that he conducted his investigation. Mr. Perry noted that when conducting a sudden death investigation, it is important to obtain all the background information possible about the deceased, and the family is generally well placed to provide that information; it is often crucial information about the next steps to be followed. In this instance, he was informed that the police had made no attempts to interview family members.

Mr. Perry testified that tunnel vision is the worst thing a police officer can bring into an interview or an investigation. He described tunnel vision as having a strong notion, therefore causing a change in the otherwise standard course of an investigation based on policy and procedure. He stated tunnel vision could cause a person to believe someone had committed a crime, or that a crime had been committed, essentially, it causes a person to believe in their theory, rather than following the evidence.

Mr. Perry had been involved in many coroners, sudden death cases. In those instances, the coroner is in charge of the death investigation, but realistically, it is the police that conduct all the interviews and secure all the evidence. He noted that there are to be regular meetings between the police and the coroner to keep each other fully informed so they can adjust their assignments accordingly. He agreed that the role of the police is essential in assisting in the determination of the manner of death or in a coroner's case.

Mr. Perry testified that he was troubled by the media releases in this matter because they concluded there was no chance of criminal activity so early into the investigation. He understood the need to alleviate public safety concerns but noted media releases must be factual, they must be evidence based. Mr. Perry agreed that the wording of a media release has potential to deter witnesses from coming forward.

David Perry – Cross Examination – Mr. Butt

Mr. Perry acknowledged since his retirement in 2004, the Major Case Management manual has evolved but noted the principles remain generally unchanged. Mr. Perry noted that investigators must be aware of cultural differences and adjust methodologies; accordingly, police must be respectful of cultural nuances or challenges. He noted that if there is mistrust, people will not come forward with information, but it is about the officer's efforts to see that that occurs. He agreed that despite those best efforts, there are times that some people will still not be willing to come forward.

Mr. Perry agreed that consultation and communication is important at the scene of a sudden death between the coroner, investigators, and the Forensic Identification Unit. Mr. Perry agreed that often, police cannot share information with family members in order to maintain investigative integrity.

Mr. Perry stated that the second media release was troubling to him because it was unequivocal, within 24 hours after the incident the matter was concluded. He agreed that in the initial media release, the terminology used implied the matter was ongoing, it did not say the investigation had been terminated, and that a post-mortem would be conducted to determine the cause of death. He agreed the message form the release is that the investigation is continuing into the cause of death.

Mr. Perry disagreed with the suggestion that there was a significant difference in the conclusiveness between the second media release and the initial media release. Mr. Perry stated that both media releases suffer from the same problem; they suggest a premature conclusion about the cause of death.

David Perry – Re-examination

Mr. Perry questioned that if the police did not know the cause of death, then how could they suggest in the initial media release that the death was not suspicious in nature. Mr. Perry stated that at a sudden death scene the lead investigator would have a role in directing the Forensic Identification Unit; the lead investigator is in charge of every aspect of the investigation. Mr. Perry stated theories would be developed which would be communicated to the Forensic Identification Unit to ensure evidence is properly gathered and managed accordingly. Mr. Perry testified that it is the responsibility of the lead investigator to ensure the scene is processed to their personal and professional standards and expectations.

Staff Sergeant Shawn Harrison – Examination-in-Chief

Staff Sergeant Harrison began his policing career in 1998 with the Ontario Provincial Police, moving to the Thunder Bay Police Service in 2000. He worked mostly uniform patrol, before commencing his assignment in the Criminal Investigation Branch in 2005. He was promoted to the rank of sergeant in 2013, returned to uniform patrol briefly and was then reassigned to the Criminal Investigation Branch in 2014 at the rank of detective.

Staff Sergeant Harrison testified that in his career, he has been very engaged with the Indigenous community and has received training related to Indigenous culture.

Staff Sergeant Harrison explained that the Criminal Investigation Branch consisted at the time, of four detectives, each of whom supervised two or three detective constables responsible for investigating major crimes such as robbery, aggravated assault, some internal investigations, homicides, and sudden death investigations.

Staff Sergeant Harrison noted that from 2009 – 2017, the Thunder Bay Police Service investigated 47 homicides, 31 of which involved victims of Indigenous descent. Of the 11 homicide investigations he led, nine involved Indigenous victims. He stated that 10 of were the 11 cases were solved, the last one after he had been transferred out of the Branch.

Staff Sergeant Harrison noted that manpower shortages were always an issue because of how busy the Criminal Investigation Branch was. He detailed the extensive training he had received which included the Homicide course and the Major Case Management course. He received the Major Case Management training in approximately 2008 and received Major Case Management facilitator training in 2015. He has instructed on the Major Case Management course annually since 2016.

Staff Sergeant Harrison testified that he was fully aware at the time of this incident, that the Inquest into the Deaths of Seven First Nations was ongoing. He stated that police were called on a weekly basis to people needing assistance after being in the river, some needed rescuing, some escaped on their own, while some others drowned.

Staff Sergeant Harrison stated he was very familiar with the location where Stacey DeBungee was found, it is a public walking/bike path but also provides for the backdrop for people to sit along the riverbank and consume alcohol. He noted that the nearby train bridge often provided shelter for some people.

Staff Sergeant Harrison testified that on October 19, 2015, he and Sergeant McKever had picked up Sergeant Whipple from the courthouse when they learned of the call for service about a body found in the river. As the Criminal Investigation Branch is responsible for

investigating all sudden deaths, they attended the scene together. It was understood that Sergeant Whipple was tied up with tasks related to his ongoing and unrelated homicide investigation, so Sergeant McKever took the initiative to take carriage of investigative lead responsibilities. Staff Sergeant Harrison testified that Sergeant McKever was his “number two” on this call for service.

Staff Sergeant Harrison noted that the scene was secured upon his arrival, he did not enter initially to prevent scene contamination. He learned that a person came across the body while out walking his dog. He was advised three people walked out of a bush area, but they knew nothing of interest. Staff Sergeant Harrison knew the coroner was attending the scene and noted that media were gathering in the area. Staff Sergeant Harrison knew this incident would generate public interest, so he requested the media relations officer attend.

Staff Sergeant Harrison directed Constable Verescak to speak to people who had arrived at the scene in a vehicle. He was not certain of when the Forensic Identification Unit attended, but acknowledged they have specialized training; they know what to seize as evidence and how to seize it. He stated that he allows them to do their job, he does not interfere.

Staff Sergeant Harrison stated he had worked hundreds of scenes with the Forensic Identification Unit by this time. He had not heard of any concerns from his experiences in court about the quality of their work. He noted that he did not take notice of the photographs taken at the scene by the Forensic Identification Unit. Staff Sergeant Harrison indicated it is not uncommon for a coroner to request certain items be photographed. He stated he does not have a role in processing the scene of a sudden death unless he observes something relevant. In this instance, he did not see anything that required him to instruct the Forensic Identification Unit to photograph.

Staff Sergeant Harrison reiterated that the Forensic Identification Unit runs the scene, they made the determination that video recording of the scene was not necessary, and he was comfortable with that decision; if he felt the need to have it recorded, he would have requested it. Similarly, if he saw evidence that ought to have been seized, he would have directed the Forensic Identification Unit accordingly.

Staff Sergeant Harrison noted that the Centre of Forensic Sciences does not receive exhibits for examination unless there is a criminal component to the request. He added that there was no cause for suspicion of foul play, therefore measurements of the riverbank and water depth were not required. Staff Sergeant Harrison testified that they believed the entry point into the water was where the body was located. When the body was removed from the water, it was done in a manner similar to what he had experienced at prior calls for service, no one questioned the procedure.

Staff Sergeant Harrison testified that he conversed with the uniform officers who were present at the scene, spoke with Mr. Adams upon his arrival, and also with the coroner. The coroner decided there would be a post-mortem examination. Staff Sergeant Harrison stated that as he recalled, the decision to release the scene was agreed upon by him, the coroner, and the Forensic Identification Unit. Staff Sergeant Harrison stated that Detective Primmer indicted she had what she needed from the scene, and he was comfortable releasing the scene but noted, if either of them thought the scene ought to have been held, he would have done so. He stated it was not common practice at the time to hold scenes of nonsuspicious crime scenes until after the post-mortem.

Staff Sergeant Harrison testified that although he did not suspect criminality, he was not dismissing the possibility. He stated he knew people frequently go in the river in this area, knew that people drink alcohol near the river in this area, and two officers, Verescak and McKever, indicated that they had dealt with Stacey DeBungee previously for alcohol related calls for service. Consequently, it was possible that alcohol was a factor. He noted that the terrain in close proximity to the riverbank may have contributed to Stacey DeBungee going into the water.

Staff Sergeant Harrison agreed that the personal identification of Mr. Sapay being found at the scene needed to be followed up on but noted the finding of discarded identification in this area was not unusual. Staff Sergeant Harrison stated that Sergeant McKever canvassed the two businesses that would have had evidentiary value, everything else was too far away.

Staff Sergeant Harrison stated that the Major Case Management manual states the principles from therein are to be engaged in instances where homicide is suspected, meaning he would have to have some belief there was a homicide; he was not of that belief and no one else at the scene was either. He stated homicide was not eliminated, but they needed to await post-mortem results and to interview Mr. Sapay.

Staff Sergeant Harrison testified that Constable Verescak did not inform him that on October 18, 2015, Mike Chartier observed four or five Indigenous people consuming alcohol in the area where Stacey DeBungee's body was located. Staff Sergeant Harrison conceded that he was the supervisor in charge of this sudden death investigation, but he did not view or approve the report submitted by Constable Verescak. The approval process that was in place, called for the report to be approved by Constable Verescak's immediate supervisor. Staff Sergeant Harrison stated the information should have been shared with him by Constable Verescak at the scene. He stated that had he known about it, he would have directed Sergeant McKever to interview Mr. Chartier immediately.

Staff Sergeant Harrison testified that the first media release was meant to notify the public about the incident while mitigating public safety concerns. He stated that he was aware of

rumors in the community that a serial killer was responsible for the deaths that gave rise to the Inquest, and he wanted to ensure the public knew the deceased person was not a child, and that foul play was not suspected.

Staff Sergeant Harrison stated that had Detective Bystrican or his immediate supervisors, Staff Sergeant Kaucharik, or Inspector Levesque had any issues with the initial media release, they would have not allowed it to be disseminated. He noted that they did not express concern then, or after it had been released. He testified that he did not ever see the second media release from October 20, 2015, and did not approve it.

Staff Sergeant Harrison stated that when he conversed with Brad DeBungee on October 21, 2015, he informed him that the death was still under investigation, that he did not believe the death was suspicious, but was awaiting results of the post-mortem examination.

Staff Sergeant Harrison stated that once he learned that Stacey DeBungee could be identified by his tattoos, he felt it was appropriate to make the next of kin notification. He sent Sergeant McKever and Sergeant Whipple to complete the task; he reiterated that it was Sergeant McKever conducting the primary work on the file, not Sergeant Whipple.

Upon Sergeant McKever and Sergeant Whipple's return to the office, he learned from them that people observed Stacey DeBungee passed out near the river. Witness statements were not obtained, but Staff Sergeant Harrison noted that the individuals were available should formal statement taking be required in the future. Staff Sergeant Harrison noted Mr. Sapay needed to be located and interviewed, but the information known about his role did not cause him to suspect foul play. He assigned Sergeant McKever to follow up with Mr. Sapay. Staff Sergeant Harrison was aware Mr. Sapay had outstanding arrest warrants meaning it was likely that he did not wish to be located. He acknowledged that sometimes people know they are wanted, other times they do not.

Staff Sergeant Harrison was informed that Sergeant McKever attended the Sapay residence and left his business card behind when he was not located. Staff Sergeant Harrison agreed with the testimony of Staff Sergeant Kaucharik as it related to the MOB, BOLO, and the fact Mr. Sapay had been in police custody on two occasions without the Criminal Investigation Branch being notified. His expectation initially was that they would be dealing with Mr. Sapay soon after posting the MOB and BOLO flags. Staff Sergeant Harrison indicated there was no expectation of Sergeant Whipple to follow up on Sergeant McKever's work product.

Staff Sergeant Harrison learned in March 2016 that Mr. Sapay was in custody. Staff Sergeant Harrison verified Mr. Sapay was in jail, and on his day off, he called into the office and asked Sergeant Whipple to accompany him for the interview. Sergeant Whipple was the only officer

working in the Criminal Investigation Branch that day. Sergeant Whipple's status had not changed, it was simply that a second officer was required to assist with the interview.

Staff Sergeant Harrison conducted the interview of Mr. Sapay while Sergeant Whipple took notes. Mr. Sapay answered questions but stated he did not recall much. Mr. Sapay told the officers that the physical altercation on October 18, 2015, was between he and his brother Corey Linklater. He also stated that he had left the area before everyone else. Staff Sergeant Harrison stated the interview did not raise suspicion and there was no reason to interview anyone else.

Staff Sergeant Harrison stated he had no hesitation meeting with Brad DeBungee when he attended the police station on October 21, 2015; at the time he was unaware that Stacey DeBungee had a brother. Staff Sergeant Harrison, Sergeant Whipple and Sergeant McKever met with Brad DeBungee and two female family members. He apologized to them that they learned of the death via social media, he explained they notified his common-law spouse, the person they believed was the appropriate next of kin.

In the meeting, Brad DeBungee wanted to know about the investigation. Staff Sergeant Harrison testified that he told him there was nothing suspicious, but they were awaiting post-mortem results. Brad DeBungee requested an inquest. Staff Sergeant Harrison explained that was not his decision to make. He did not discourage Brad DeBungee when he indicated he had a lawyer. Staff Sergeant Harrison provided each of them with his business card and asked them to contact him if information developed. Staff Sergeant Harrison did not consider conducting a formal interview of Brad DeBungee, it would not have advanced the investigation.

By chance, Staff Sergeant Harrison saw Brad DeBungee a short time later as he attended a business for personal reasons located next to the sudden death scene. He approached Brad DeBungee and showed him where his brother had been located. Staff Sergeant Harrison testified that he told them that the police did not know if Stacey had stumbled into the river or rolled in, and they might never know.

That same afternoon, Staff Sergeant Harrison learned that the post-mortem had been completed and that it revealed no injury to the body. He stated that there was no foul play suspected, reaffirming his position that this was not a homicide but the toxicology report was pending so foul play had not been ruled out.

Staff Sergeant Harrison stated that no one other than Mr. Sapay needed to be formally interviewed. Marie Spence was spoken to at the scene, one of the three that walked out of the bush. She provided a pseudo name but her being interviewed would not have advanced the investigation.

Staff Sergeant Harrison stated that police did not have sufficient grounds to obtain a production order or a search warrant to obtain Stacey DeBungee's banking records based on the information they had at the time.

On November 24, 2015, Brad DeBungee attended the Thunder Bay Police Service and met with Staff Sergeant Harrison. Brad DeBungee was upset that Staff Sergeant Harrison had not returned his call. Staff Sergeant Harrison testified that he wanted to converse with the regional coroner before the meeting; he had put in a call but had not heard back.

Staff Sergeant Harrison testified that Brad DeBungee accused him of not properly investigating his brother's death. Staff Sergeant Harrison directed him to submit a freedom of information request as he was not able to provide the answers he was seeking. Brad DeBungee insinuated the poor investigation was race related. Staff Sergeant Harrison made him aware of his homicide investigation success rate having solved 10 of his 11 cases, the majority involving Indigenous victims. Brad DeBungee suggested the necessary information must have fallen into Staff Sergeant Harrison's lap. Staff Sergeant Harrison acknowledged that he was not quick to shake hands with Brad DeBungee at the conclusion of their meeting, but realized he was a grieving family member and shook hands.

Staff Sergeant Harrison acknowledged that prior to that meeting, he received information that David Perry was looking to speak with him. He admitted that not calling him back was a mistake on his part. During their meeting. Brad DeBungee did not make Staff Sergeant Harrison aware of the information that Mr. Perry was looking to share with him.

Staff Sergeant Harrison stated the fact that he had a busy work schedule did not prevent him from conducting a more thorough investigation, he did what was appropriate and necessary. He stated that he kept his supervisors apprised of the investigation and they expressed no concerns. Staff Sergeant Harrison testified that he was unaffected by the cultural backgrounds of those he is working with in an investigation; race did not affect how hard he worked on this sudden death investigation. Staff Sergeant Harrison stated there was no suspicion of foul play in this death investigation, but he never closed his mind about what may have happened to Stacey DeBungee.

<u>Staff Sergeant Shawn Harrison – Cross Examination – Mr. Dubois</u>

Staff Sergeant Harrison testified that other than not contacting Mr. Perry, the work he and his subordinates conducted pertaining to this investigation was exemplary. In his statement to the OIPRD, Staff Sergeant Harrison stated the investigation was not related to systemic racism. Staff Sergeant Harrison testified that he was not sure what systemic racism is. He indicated he had not read the Broken Trust report, nor the report submitted by Senator Sinclair marked as Exhibit #7B.

Staff Sergeant Harrison acknowledged that the Agreed Statement of Facts indicated "Sergeant Whipple was part of Staff Sergeant Harrison's investigative team." He clarified however, that Sergeant Whipple had little to do with the case, he provided assistance as needed, but Sergeant McKever completed the bulk of the work. Staff Sergeant Harrison was uncertain why Sergeant Whipple was contacted by the Chief of Police about this file indicating that Sergeant Whipple had not even submitted any reports at that time. Staff Sergeant Harrison stated that it was primarily him and Sergeant McKever working this case, Sergeant Whipple's role was minor and corresponded with the times when Sergeant McKever was unavailable.

Staff Sergeant Harrison stated that as the lead investigator, he is able to intervene if he felt that a member of the Forensic Identification Unit missed a piece of evidence that ought to be seized. He believed that at that time in 2015, scenes were not being video recorded.

Staff Sergeant Harrison stated that while at the sudden death scene, he was aware that Stacey DeBungee was Indigenous and knew that he had previous *Liquor Licence Act* infractions. Staff Sergeant Harrison stated he was not surprised to learn the toxicology report indicated Stacey DeBungee had been consuming alcohol, it was what he had expected based on the information provided to him.

Staff Sergeant Harrison stated there was no evidence at the scene such as skid marks in the grass or dirt indicating there had been a shoving match. Staff Sergeant Harrison stated Sergeant McKever looked for surveillance cameras at the local businesses, he did not see any but conceded he may not have entered the businesses. He confirmed that despite Mr. Sapay's identification located in close proximity to the deceased, at no point had he uncovered evidence that suggested foul play.

Staff Sergeant Harrison testified that he knew people often went in the water in this area, knew that Stacey DeBungee had a history of public intoxication and he believed he had been drinking. Additionally, he stated there were no signs of injury or trauma, and no one was coming forward suggesting something suspicious occurred. Staff Sergeant Harrison stated the investigation was continuing, they had to interview Mr. Sapay but there was no need to hold the scene as it was a nonsuspicious death.

Staff Sergeant Harrison stated that in sudden death investigations deemed coroner's cases, there is no criminality and the police simply provide assistance; this case appeared to be a coroner's case pending the results of the post-mortem. Staff Sergeant Harrison stated that it was not his responsibility to search for people with outstanding arrest warrants; he was too busy with other investigations. He acknowledged it was five months before Mr. Sapay was located and interviewed and confirmed the death was treated as a coroner's case during that time.

Staff Sergeant Harrison acknowledged that the public, in reading the initial media release, might interpret it as the investigation being over, but he remained comfortable with the manner in which the initial media release was worded. In his statement to the OIPRD, Staff Sergeant Harrison indicated that he "probably" approved the second media release. He testified however that he did not approve it and had not seen it prior to this misconduct complaint.

As noted, Constable Verescak documented the information provided to him by Mr. Chartier in the Sudden Death Report found at tab 14 of Exhibit #5. Staff Sergeant Harrison testified that he did not read the report and was unaware of the information associated to Mr. Chartier. He explained that the records management system at the time sent the report to Constable Verescak's immediate supervisor for approval, he was not notified. He agreed that the report was entered at 1:28 p.m. on October 19, 2015, and was available for anyone to read after that time. He agreed that he did not read the reports submitted in relation to this file at the time other than approving the ones that came to his attention for that administrative purpose.

Staff Sergeant Harrison stated that he could not recall if he left the scene before the uniformed officers. He agreed that in the Supplementary Occurrence Report he submitted in on October 19, 2015, in relation to Stacey DeBungee being reported as missing, he indicated that the detectives left the scene prior to the unformed officers.

Staff Sergeant Harrison agreed that the Criminal Investigation Management Plan indicates that the detective has a responsibility to know policy including ensuring this sudden death investigation complied with this plan. Staff Sergeant Harrison testified that in fact his investigation did comply. Staff Sergeant Harrison stated that there was no evidence suggesting the death was a homicide, but he was open to the possibility. Consequently, the matter did not fall under the Major Case Management guidelines.

Staff Sergeant Harrison stated that he would have read and approved the Supplementary Occurrence Report submitted by Sergeant McKever which indicated an unidentified male was present at the next of kin notification meeting. He agreed the male could have been Mr. Sapay. Staff Sergeant Harrison agreed that through this meeting, he learned that Stacey DeBungee had been drinking at the scene the previous evening and was passed out due to alcohol consumption.

Staff Sergeant Harrison agreed that the next investigative step was to locate Mr. Sapay, and the last investigative step was to add the MOB and the BOLO. He did not go back and check the status of these flags; it was the usual process that they would result in the investigating officers being contacted when Mr. Sapay was located.

Staff Sergeant Harrison reiterated that he was not certain why the chief of police contacted Sergeant Whipple considering his role was so minor.

Staff Sergeant Harrison stated that he did not show Mr. Sapay a photograph of Stacey DeBungee during his interview, he did not have access to one at the time and he was not certain doing so would have been helpful considering the passage of time and alcohol consumption at the time.

Staff Sergeant Harrison agreed that he received information from Mr. Sapay that contradicted the information investigators heard at the next of kin meeting. He did not consider re-interviewing others; he attributed the information discrepancy to the passage of time and alcohol consumption at the time.

Staff Sergeant Harrison stated that during his meeting with Brad DeBungee on October 21, 2015, he inquired as to whether his brother had been killed. Staff Sergeant Harrison testified that he told the family he did not know if Stacey stumbled into the river or if he fell into it. He agreed that was not included in his Supplementary Occurrence Report marked as Exhibit #12, or in his notebook entries.

Staff Sergeant Harrison agreed that in his meeting with Brad DeBungee on November 24, 2015, he did not ask him about the information Mr. Perry may have had. He conceded he was unhappy that a private investigator was asking about his investigation. He acknowledged the material as noted in the Agreed Statement of Facts, is information he would have gleaned had he met with Mr. Perry.

Staff Sergeant Harrison agreed he never requested to receive a formal interview from Brad DeBungee. Staff Sergeant Harrison denied each of the allegations from the particulars of allegations as they were put to him by Mr. Dubois other than acknowledging that he failed to meet with Mr. Perry.

<u>Staff Sergeant Shawn Harrison – Cross Examination – Ms. James</u>

Staff Sergeant Harrison agreed it is his usual practice to allow the Forensic Identification Unit to gather evidence before entering a scene and to then walk the scene to ensure they gathered all available evidence. In this instance, it was not necessary as he could clearly view the scene from a distance outside the perimeter and he was satisfied with the Forensic Identification Unit results.

Staff Sergeant Harrison stated that one of the possibilities they were considering was that Stacey DeBungee was intoxicated, rolled into the river, and drowned. He conceded no alcohol bottles were found at the scene; the theory was based on Stacey DeBungee's previous *Liquor Licence Act* offences and that there had been similar examples of this occurring in the past. Staff Sergeant Harrison was asked if the persons involved in the previous incidents were Indigenous, he indicated, "probably." He testified that he would have conducted the same investigation had the found body been Caucasian rather than Indigenous.

Staff Sergeant Harrison stated that he likely discussed this theory at the scene with the others present, but he could not recall if it was discussed with the coroner, nor could he recall if other theories were discussed at the scene.

Staff Sergeant Harrison agreed that at a sudden death scene, the lack of visible injuries alone does not cause the matter to be deemed nonsuspicious. He stated that the initial media release suggested the death was nonsuspicious based on the lack of evidence to suggest otherwise. He conceded he did not have evidence at that time that Stacey DeBungee had been consuming alcohol the previous night, and he did not know how he ended up in the river. Staff Sergeant Harrison stated that he relied on his experience, knowing that this was a frequent occurrence.

Staff Sergeant Harrison stated that the incident was not deemed a major case, therefore, the reporting system was not such that the incident reports came to him for review or approval. He did not read the Sudden Death Report at the time; he would have had been identified as a suspicious death. He agreed that the Sudden Death Report contained information that would have been relevant to the investigation.

Staff Sergeant Harrison testified that he did not learn of the physical altercation involving Indigenous people at the river until this OIPRD complaint was received. That caused him to read the reports and then interview Mr. Sapay.

Staff Sergeant Harrison stated he had extensive experience investigating sudden deaths deemed coroner cases. He agreed that police gather evidence to assist the coroner in determining how the death occurred, and in this instance, it was not known how Stacey DeBungee ended up in the river. He stated, upon reading the post-mortem report, he did not consider taking investigative steps to determine how he got in the water.

Staff Sergeant Harrison stated that the inconsistencies in Mr. Sapay's statement from the information received at the next of kin meeting did not need to be reconciled because they had been consuming alcohol, and the passage of time between the interview and the incident.

Staff Sergeant Harrison was asked if his decision to not meet with Mr. Perry was a conscious decision, as opposed to something he forgot to do. He stated he entered a guilty plea to neglect of duty for failing to do so.

<u>Staff Sergeant Shawn Harrison – Re-examination</u>

Staff Sergeant Harrison stated it is normal for people on the same investigative team in the Criminal Investigation Branch to have different caseloads. He noted that it was common at that time to release death scenes in advance of the post-mortem if the death was

nonsuspicious in nature. Staff Sergeant Harrison stated that it is the responsibility of the Forensic Identification Unit to authorize the release of exhibits.

Sergeant Shawn Whipple – Examination-in-Chief

Sergeant Whipple worked for Correctional Services for seven years before commencing his career with the Thunder Bay Police Service in 2000. He was assigned to the Criminal Investigation Branch in 2011 and remained there until his promotion to sergeant in 2016. He agreed that the Indigenous community accounted for some roles in a large number of the matters he had been involved in, including in his previous career as corrections officer.

Sergeant Whipple noted that at the time of this incident, his Criminal Investigation Branch platoon consisted of him, Staff Sergeant Harrison, and Sergeant McKever. He noted that everyone carried their own, very different caseloads. The individual caseload at the time dictated who would take carriage of the next file. In this instance, Sergeant McKever took the lead on this sudden death occurrence because Sergeant Whipple was involved in a homicide trial which necessitated satisfying immediate disclosure obligations at the request of the crown attorney.

Sergeant Whipple stated he needed a ride from the courthouse, so Staff Sergeant Harrison and Sergeant McKever picked him up. Subsequently, they attended the call for service of a male found in the river. There had been conversation in the car about him being dropped off at the office first, but it was decided that he would attend the scene.

Sergeant Whipple testified that Sergeant McKever indicated he would take carriage of the file and started completing tasks. Sergeant Whipple stated that he remained in the car for some time, making phone calls in relation to his disclosure obligations related to the other file. Afterward, he offered assistance, but by then, Sergeant McKever had already canvassed the local businesses and there was no one to interview. Sergeant Whipple made observations and recorded them in his notes.

Sergeant Whipple stated it was common practice at the time to release sudden death scenes prior to the post-mortem if there was nothing suspicious about the death. Sergeant Whipple testified that he did not participate in any decisions being made at the scene. Later, he was directed to make the next of kin notification with Sergeant McKever.

Sergeant Whipple stated Sergeant McKever as the lead investigator, would be responsible for making the next of kin notification, but protocol called for two officers to attend those types of calls for service. Sergeant Whipple stated the residence was a house but set up as a four-plex with apartments on either side of the landing. He noted that there was a group of people in a small room, such that there was not much room to move. He remained at the threshold of the

door while Sergeant McKever conversed inside. Sergeant Whipple stated he was distracted while Sergeant McKever was speaking, by what sounded like a domestic situation in the apartment across the hallway. Sergeant Whipple met with the female person from that apartment.

Sergeant Whipple testified that he was “scattered” at the time, distracted between the domestic situation and the next of kin notification. He noted this was reflected in his unfinished notebook entry. Consequently, he was unsure of the details related to the next of kin notification meeting. He noted that Sergeant McKever made the notification, took notes, and entered the Supplemental Occurrence Report; there was no expectation that he would also complete a report.

The following day, Sergeant Whipple accompanied Sergeant McKever to the last known address for Mr. Sapay. He noted that he was assisting, Sergeant McKever continued in the role of lead investigator. Sergeant McKever submitted the report indicating Mr. Sapay was not located and his whereabouts were not known.

On October 21, 2015, Staff Sergeant Harrison asked Sergeant Whipple to accompany him for a meeting. Brad DeBungee had attended the front desk seeking information and Sergeant McKever was unable to assist. He noted that Brad DeBungee was upset that he was not notified of his brother’s death personally by the police. Sergeant Whipple indicated Staff Sergeant Harrison did most of the talking, stating that the police did not know how Stacey DeBungee had ended up in the river.

On May 24, 2016, Sergeant Whipple received a call from Chief Levesque seeking information about this investigation. He was not certain why he was selected as the point person by the chief, but he directed the chief to Staff Sergeant Harrison or Sergeant McKever.

Sergeant Whipple detailed the other investigations that were assigned to him at the time; he was very busy, but those duties did not prevent him from working on this file.

On March 28, 2015, Staff Sergeant Harrison was on a day off, Sergeant Whipple was the only person working in the office that day. Staff Sergeant Harrison called and informed him that Mr. Sapay was in custody and requested his assistance in conducting an interview at the jail. Accordingly, Sergeant Whipple was present while Mr. Sapay was interviewed by Staff Sergeant Harrison. Sergeant Whipple noted that Mr. Sapay had very little recollection of the incident, he needed to be prompted initially about the nature of the investigation.

Sergeant Whipple stated that the cultural background of the victim never affected the quality of his work. He stated he has conducted hundreds of investigations and he is proud of his work including that involving Indigenous complainants. Sergeant Whipple provided examples

of his positive contact with members of the Indigenous community. He noted that he did not pull away from this investigation whatsoever as a result of Stacey DeBungee's race.

Sergeant Shawn Whipple – Cross Examination – Mr. Dubois

Sergeant Whipple agreed that it in this case, it was the role of the Thunder Bay Police Service to determine how Stacey DeBungee ended up in the river, it was the coroner's role to determine cause of death.

Sergeant Whipple testified that he remained at the top of the hill when the body was in the water and when it was removed from the water, he never viewed the body personally. He heard an officer indicate they thought it was Stacey DeBungee, a name not known to Sergeant Whipple. He did not recall if the officer indicated how they knew Stacey DeBungee and he did not recall there being a reference to alcohol at the scene.

Sergeant Whipple stated that he formed no opinion at the scene as to how Stacey DeBungee found himself in the river, but he knew people consumed alcohol in that general area and he considered it possible that Stacey had been drunk at the time. He agreed there was no alcohol bottles found in the area and agreed that no trauma to a body does not indicate that therefore there is no criminality.

Sergeant Whipple stated he did not read Constable Verescak's Sudden Death Report or Sergeant McKever's Supplementary Occurrence Report at the time, he was never directed to read them, and had no cause to do so based on his limited involvement.

In terms of formal statements from those at the next of kin meeting, Sergeant Whipple stated that it was Sergeant McKever's responsibility as the lead to determine the necessity.

Sergeant Whipple testified that during the October 21, 2015, meeting with Brad DeBungee, the only theory shared by Staff Sergeant Harrison was that Stacey DeBungee may have rolled into the river, but it was also noted that they did not know how or why he ended up in the river.

Sergeant Whipple stated that the family had concerns about how Stacey got into the river, but he did not recall them suggesting he was killed by someone. He agreed that in his statement to the OIPRD at tab 27 of Exhibit #5, he indicated that the family was concerned Stacey had been killed.

Sergeant Whipple agreed that it has been accepted that systemic racism exists in the Thunder Bay Police Service. He had not read the Broken Trust report, or the Thunder Bay Police Services Board Investigation - Final Report by Senator Sinclair.

Sergeant Whipple denied that he and Staff Sergeant Harrison made premature assumptions about the cause of Stacey DeBungee's death due to his Indigenous status and denied the specific assertions related to the neglect of duty allegation.

Sergeant Shawn Whipple – Cross Examination – Ms. James

Sergeant Whipple noted that in the Criminal Investigation Branch, officers assisted with other files as required, they did not take carriage of another officer's file. In so doing, an officer is not expected to know all the circumstances related to another officer's investigation. Sergeant Whipple stated he would not expect an assisting officer to review the reports from another member's file if they were merely assisting the lead investigator with an interview for example.

Sergeant Whipple stated that Staff Sergeant Harrison was off duty when he called him and asked him to assist with interviewing Mr. Sapay. He did not consider reviewing the file in advance, he was confident that Staff Sergeant Harrison would know the relevant information necessary to conduct the interview. He agreed that it would not have been too time consuming to read the reports associated to the file.

Sergeant Whipple agreed that he did not file a report or make a notebook entry about the disturbance at the next apartment from the next of kin notification. Sergeant Whipple stated that he was surprised when he was contacted by the chief in 2016 and suggested to him that he contact the officers engaged in the file, Staff Sergeant Harrison, or Sergeant McKever.

Sergeant Whipple testified that although he had no personal experience executing a coroner's warrant, he was familiar with its existence and noted that a criminal offence is required to obtain a production order. He stated that he would not have conducted himself any differently if this was a criminal investigation. Sergeant Whipple stated that he never asked Staff Sergeant Harrison or Sergeant McKever about their theories, they are capable investigators, and he was engaged in his own files.

Sergeant Whipple stated that he submitted the report concerning the David Sapay interview, but he was not involved any further afterwards as the file was reassigned the following day.

Sergeant Whipple stated that he was not the primary investigator on the investigation and consequently, he did not make note of inconsistencies that arose as a result of the interview, it was not his role to do so.

Submissions

Defence Submissions

Mr. Butt's Book of Authorities is Exhibit #13. In addition, Mr. Butt submitted a written volume of his oral submissions, marked as Exhibit #14. He did not touch on every component of his written submissions in his oral submissions but noted that all aspects of his written and oral submissions were to be relied upon.

Mr. Butt submitted, this tribunal is not an inquiry, nor is it a human right tribunal, accordingly, I must be mindful of the applicable rules. The standard of proof is that of clear and convincing evidence which is greater than a balance of probabilities. He noted that the evidence must be weighty, cogent, and compelling.

Mr. Butt submitted that case law on the standard for neglect of duty makes the following points:

- For it to be misconduct, it must be established that it was an intentional failure to perform something that was required; inadvertence is not enough.
- Police work that is merely sloppy, sub-standard, or an honest mistake, does not amount to neglect of duty.
- Neglect of duty is not a tool to second-guess the exercise of discretion.
- Systemic practices, carried out in general and in good faith are not neglect of duty.

Mr. Butt cited the matter of *Gauthier v Toronto Police Service* (2021) where the subject officer failed to take a sworn statement from a witness which was contrary to policy, but consistent with common practice at the Toronto Police Service at the time. The hearing officer took into account the systemic practice at the time in acquitting the officer of neglect of duty.

Mr. Butt submitted the test for discreditable conduct is primarily an objective test, but it does incorporate a subjective element of good faith. It requires an assessment of whether the impugned actions would bring discredit upon the police service in the eyes of the reasonable, impartial, and fully informed person.

Mr. Butt submitted Human Rights notions like unconscious bias have no place in this tribunal because it is a fundamental requirement for punishment that there be a blameworthy act. Mr. Butt submitted unconscious bias is something we all have in different ways and to different degrees, it is not something that warrants punishment; unconscious bias is addressed by identification and education.

Mr. Butt submitted I ought to take the same approach as the hearing officer in the *Gauthier* case with respect to the Broken Trust report and the Thunder Bay Police Services Board Investigation - Final Report by Senator Sinclair. In *Gauthier*, the hearing officer noted:

> I am aware that the Honourable Justice Epstein conducted a review of how the Toronto Police handled cases of missing persons and that her report was released shortly prior to the commencement of this hearing. I refrained from reading Justice Epstein's report to prevent myself from being made aware of details which might not arise during the hearing. Since I do not know the details of her findings, I believe it is important to recognize that any discrepancies between her findings and mine are the result of the scope of our mandates. I expect Justice Epstein's review will be systemic in nature with a focus on best practices while my focus is on whether Sergeant Gauthier disobeyed policy during one incident. As such, the Honourable Justice's perspective may be quite broad and far reaching, whereas my role as an adjudicator had a very narrow focus. Additionally, Justice Epstein's review will likely to be more fulsome with the amount of information that was available for her consideration, while I am limited to what was provided to me during this hearing. Nothing in my decision should be construed as contradictory to Justice Epstein's report.

Mr. Butt submitted the Broken Trust report has a limited role, the systemic review does not inform the tribunal whether the allegations have been made out based on the standard of clear and convincing evidence. The report related to the *Gauthier* matter was, similarly, a systemic review into how the Toronto Police Service handled missing person investigations. The hearing officer did not consider it in fact did not even read it.

Mr. Butt submitted a systemic review takes a macro perspective, whereas a discipline hearing takes a micro perspective, an inquiry into the operation of systems is very different than an inquiry into the isolated acts of individuals. Mr. Butt submitted the Broken Trust report has no punishment-oriented recommendations, instead, they are meant to accomplish widespread organizational change: resourcing, education, systemic change, and outreach. Punishment oriented discipline proceedings are directed at the particular acts of particular individuals. Mr. Butt noted that the Broken Trust report is not impacted by findings from this tribunal suggesting the report applied a lower standard of proof than must be applied here. Mr. Butt added, Staff Sergeant Harrison was specifically told by the OIPRD interviewer that he would not be asked questions about the systemic issues. The transcripts were kept separate and systemic evidence was not used to advance the conduct investigation. Mr. Butt submitted it would be improper to utilize the Broken Trust report as it would breach the promise made by lead counsel of the OIPRD that the two would be kept separate and it would import findings into this hearing that were not subjected to the standard of proof required for this hearing, thereby diluting the standard of proof in this hearing.

Mr. Butt noted that much of the evidence in this case was not contested. He submitted that the evidence was overwhelmingly clear that Sergeant Whipple was not part of the investigation; being on the same shift is not the same as being assigned to a case. He noted that the criminal investigators' work distribution was not mechanical, they informally took on

tasks based on the current workload being managed by the members. Mr. Butt submitted that in this case, Sergeant Whipple was literally along for the ride and did what was needed to help, but he did not have primary responsibility for completing tasks. Prior to being contacted by the chief in 2016, he had not even completed a report.

Mr. Butt submitted Sergeant McKever was the lead detective constable on the case, there is no evidence to suggest Sergeant Whipple had any responsibilities associated to the investigation.

Mr. Butt noted Staff Sergeant Harrison acknowledged from the outset of this hearing that he is guilty of neglect of duty for failing to meet with Mr. Perry, but submitted, that is the only neglect he is guilty of. Mr. Butt submitted Staff Sergeant Harrison did not commit misconduct for failing to treat the sudden death as a homicide for a number of reasons: a death where homicide is a possibility, cannot be a suspected homicide unless there is an evidentiary foundation for the suspicion, no such evidence existed in this case; the Coroner informed the OIPRD that the police formed no conclusions and had not ruled out foul play; Staff Sergeant Harrison never closed his mind to the possibility of this case being a homicide but no evidence that came to his attention grounded a suspicion of homicide despite him keeping an eye out for evidence that may have pointed at a crime.

Mr. Butt submitted Staff Sergeant did not commit misconduct by failing to use the Major Case Management system. He noted that the Major Case Management System does not apply to all sudden deaths, it applies to those deaths suspected of being a homicide. In this case, Staff Sergeant Harrison had no evidence that could properly ground a suspicion of homicide making his decision not to invoke the Major Case Management system, reasonable.

Mr. Butt noted that Staff Sergeant Harrison was at the time, experienced with Major Case Management, he is a certified Major Case Management instructor and has been for years. Mr. Butt submitted that based on his training and experience, his testimony about whether or not this case falls into Major Case Management deserves considerable deference.

Mr. Butt submitted Staff Sergeant Harrison did not commit misconduct for the manner in which the Forensic Identification Unit did their work, including the decision about submitting evidence for forensic examination. Mr. Butt submitted the Forensic Identification Unit has specialized skills that they deploy using their own judgment when they process a scene. The individual Forensic Identification Unit officers answer to their unit superiors, not the lead investigator on scene. Mr. Butt submitted the lead investigator on scene does not micromanage officers from the Forensic Identification Unit because he or she does not have the requisite specialized identification knowledge, training, and experience to do so.

Mr. Butt submitted Staff Sergeant Harrison was entitled to rely on the expertise of his Forensic Identification Unit colleagues as he did, they had over the years, earned his trust and he trusted them to do their job. Mr. Butt submitted Staff Sergeant Harrison was actively engaged at the scene, he consulted with the Forensic Identification Unit, and with the coroner. Each shared their own particular professional perspective with the others, reaching a consensus on releasing the scene. Staff Sergeant Harrison testified that if anyone wanted to hold the scene, it would not have been released, it was a collaborative decision made in good faith.

Mr. Butt stated that the reason no one is criticizing the coroner or members from the Forensic Identification Unit is because the consensus reached by all three was reasonable and consistent with common practice at the time. Mr. Butt noted that the Thunder Bay Police Service sudden death policy specifically states that it is the responsibility of the Forensic Identification Unit, not the lead investigator, to take charge of the scene, conduct the forensic examinations necessary, arrange scene security, and release the scene.

Mr. Butt submitted Staff Sergeant Harrison is an experienced investigator, he was aware that the Centre of Forensic Sciences would not accept exhibits for analysis unless a crime was being investigated. He noted that Staff Sergeant Harrison always had an open mind, the absence of an evidence-based suspicion of a crime meant the exhibits could not be sent for forensic analysis.

Mr. Butt submitted Staff Sergeant Harrison did not commit misconduct in relation to the two media releases. He submitted that the initial media release fairly and reasonably, balanced the competing objectives in play at the time, the public had to be re-assured as much as possible, and the public had to be informed that the investigation was ongoing, and that no final conclusion had been reached. Mr. Butt submitted the first media release was carefully analyzed in evidence by multiple witnesses, including those called by the public complainant; the evidence was overwhelming that the first press release fairly balanced the competing objectives being pursued early in the investigation. Mr. Butt added, any reasonable reader of the first press release would conclude that the investigation was in its early stages and no final conclusions had been drawn.

Mr. Butt submitted that the only dissenting witness on the propriety of the initial media release was Mr. Perry, and his evidence should be rejected. Mr. Butt submitted Mr. Perry's description of being "horrified" by the treatment of the Thunder Bay Police Service during his brief attendance at the station was over-blown rhetoric that betrayed partisanship while Mr. DeBungee's account did not come close to describing the experience as horrifying.

Mr. Butt submitted that in claiming that both press releases were equally problematic, ignored the differences between them, illustrating that Mr. Perry demonstrated a lack of common sense, a lack of judgment, and over-reaching partisanship. Mr. Butt noted that in his OIPRD

interview, Mr. Perry stated, “in fairness to the police, sometimes they would make an announcement for public safety and to ease the community’s fears,” a stance that was inconsistent with his one-sided approach in his testimony.

Mr. Butt conceded the second press release is problematic, unlike the first, its language is conclusive, it does not reference investigative steps still to be taken. He stated it was wrong and should not have gone out, but the evidence does not show that Staff Sergeant Harrison was responsible for sending it out. Mr. Butt noted that Chris Adams could not say who approved the second media release. Unlike the email trail created for the first press release, there is no such email trail for the second. Staff Sergeant Harrison in his OIPRD interview, stated he “probably” approved it but also suggested that was just a guess. Mr. Butt submitted a guess that someone probably did something is anything but clear and convincing evidence; furthermore, Staff Sergeant Harrison testified that he did not approve it.

Mr. Butt submitted that Staff Sergeant Kaucharik acknowledged in her evidence that she discussed the media release with Chris Adams, which may have been misconstrued by him as approval, but in any event, points away from Staff Sergeant Harrison as the one authorizing it.

Mr. Butt submitted that Staff Sergeant Harrison’s evidence that he did not approve the media release is reasonable because he told Brad DeBungee when they met, that they did not know the cause of death, and thus could not possibly have conclusively deemed it non-criminal. Conversely, when the press release went out, Staff Sergeant Harrison knew that there was an outstanding interview to be conducted with David Sapay. Staff Sergeant Harrison is, on the evidence of his superiors who were called by the public complainant, an exemplary officer. Therefore, it makes no sense that he would approve such a conclusive press release when a key witness remained to be interviewed.

Mr. Butt submitted that since it cannot be proven on clear and convincing evidence that Staff Sergeant Harrison was responsible for approving the second press release, he cannot be found guilty of misconduct for having sent it out, regardless of how improper it was.

Mr. Butt submitted Staff Sergeant Harrison did not commit misconduct as his behaviour related to interviews that were or were not conducted. Mr. Butt submitted that when Sergeant McKever did the next of kin notification, he advised that persons present in the apartment said they were with Stacey DeBungee on the night in question, and that when they left him, he was passed out with David Sapay. Mr. Butt stated that information provided no reasonable basis to suspect homicide, nor did it provide insight into how Stacey DeBungee may have died. Mr. Butt stated the information provided no reasonable basis to believe these witnesses had anything more helpful to say than what they had provided; the decision not to interview these individuals does not rise to the standard of neglect.

Mr. Butt submitted Constable Verescak spoke to a male at the scene who said he encountered Native Canadians drinking in the area and saw two males “pushing each other around near the area of the fence on the west side of the bike path.” Constable Verescak was a uniform constable, so his report was approved in the usual course, by his uniform supervisor. This division of responsibility between uniform supervisors and the lead investigator on the sudden death in the Criminal Investigation Branch meant that the report did not come to the attention of Staff Sergeant Harrison in the usual course. Had it come to his attention, he acknowledged that follow-up would have been warranted. The information was never delivered to Staff Sergeant Harrison, it was only included in the report drafted by Constable Verescak.

Mr. Butt acknowledged that it took months for David Sapay to be interviewed, but suggested the problem was systemic, not neglect of duty. He noted that Mr. Sapay could not be found when Sergeant McKever attended where Mr. Sapay was required by court conditions to be residing. Furthermore, Mr. Sapay was also wanted on a warrant. As it is not uncommon for people who are wanted on warrants to make themselves scarce, Mr. Sapay was put on the system as a person of interest in the Stacey DeBungee sudden death.

Mr. Butt noted Mr. Sapay was listed as a person of interest, but only in the case file, not under his own name, meaning an officer encountering Mr. Sapay who looked only under his name, would not get the information that he was a person of interest in the DeBungee death; it is a systemic problem which cannot be blamed on Staff Sergeant Harrison; he was entitled to rely on a notice system that would, if it worked properly, empower every officer out on the street to bring in Mr. Sapay if they came across him.

Mr. Butt noted Mr. Sapay ended up in custody twice, without anyone notifying Staff Sergeant Harrison. Detective Harrison cannot be blamed for not acting on information that was not shared with him. Detective Harrison testified that once Mr. Sapay’s name was put on the system, he expected to be in touch with him shortly. Mr. Sapay did end up being found and taken into custody twice, but the systemic flaw prevented Staff Sergeant Harrison from finding out which does not amount to neglect of duty.

Mr. Butt submitted the Ontario Provincial Police review turned up nothing that pointed to neglect of duty by Staff Sergeant Harrison. The review as summarized in the Agreed Statement of Facts, first focused on several steps that second guess the professional judgment of the Forensic Identification Unit officers on scene. Mr. Butt noted Stacey DeBungee’s body was removed in a manner consistent with practice to date, that met with the approval of not only Staff Sergeant Harrison, but the identification officers present and the coroner as well. Mr. Butt submitted not measuring the slope of a riverbank that the officers were abundantly familiar with does not amount to misconduct. Mr. Butt added, that at the scene, the immediately adjacent buildings were checked for video, and given the distance of the buildings across the river, nothing would realistically be served by canvassing them.

Mr. Butt submitted that the objective standard of discredit in the eyes of the fully informed and dispassionate member of the community, with due allowance for good faith, means that there is no room to punish based on Human Rights notions like unconscious bias. Mr. Butt submitted that because Sergeant Whipple is not guilty of neglect of duty, it is impossible to suggest he is guilty of discreditable conduct for neglecting his duties due to racism. Furthermore, any suggestion that Sergeant Whipple is racist, flies in the face of the uncontradicted evidence. He is a diligent, committed, and compassionate police officer. He is regarded as exemplary by his supervisors who testified. He has provided abundant evidence of the high regard in which he is held by numerous indigenous people he has served as a police officer. He has gone the distance repeatedly and successfully for his Indigenous victims, who make up the majority of his victims. Mr. Butt submitted the evidentiary record is of void of any hint of racism attaching to Sergeant Whipple as a person and a police officer. His record of service to the Indigenous community is exemplary.

Mr. Butt submitted the same could be said for Staff Sergeant Harrison, he too is an exemplary officer in every respect. Everyone from Deputy Chief Hay, through Staff Sergeant Kaucharik to Sergeant McKever, all testified racism has nothing to do with how he does his job. The coroner and the paramedic on scene were asked if the police officers at the scene were not working as hard because the deceased was Indigenous, and they said definitely not.

Mr. Butt submitted Staff Sergeant Harrison proved in the witness box to be a sensitive, open-minded, committed, and self-critical officer who went the extra mile whenever needed to solve multiple homicides involving indigenous victims. His erroneous decision not to talk to Mr. Perry had nothing to do with race, as he spoke on multiple occasions with Brad DeBungee directly, even going out of his way to go down to the riverbank to help Brad DeBungee know where Stacey was found.

Mr. Butt submitted that when the evidence is considered fairly and, in its totality, it shows that Staff Sergeant Harrison's record in serving the Indigenous community is exemplary. There is no evidence credibly suggesting racism had anything to do with anything he did in this case, much less clear and convincing evidence.

Mr. Butt submitted systemic racism is a problem to be addressed, but this hearing must not be driven by emotions, it must be driven by reasonableness, procedural fairness, and clear and convincing evidence. Mr. Butt stated that apart from the one instance of neglect of duty for which there is a plea of guilty, there is no clear and convincing evidence that clears the high legal bars set for discreditable conduct and neglect.

Prosecution Submissions

Mr. Dubois submitted the law on the standard of proof is clear as noted in the matter of *Jacobs v. Ottawa Police Service*, 2016 ONCA 345, found at tab 1 of Mr. Butt's Book of Authorities.

Mr. Dubois noted that Staff Sergeant Harrison and Sergeant Whipple are charged with neglect of duty under section 2(1)(c)(i) of the Code of Conduct. He cited the matter of *Hewitt and Toronto Police Service,* 1999 CanLII 31607 (ON CPC) which stated:

> Both officers in this case are charged with neglect of duty. Under section 1(c)(i) of the Code, neglect of duty is defined as "without lawful excuse, neglects or omits promptly and diligently to perform a duty as a member of the police force.
>
> Essentially, this is a two-part test. As the Commission stated in *Soley and Ontario Provincial Police*:
>
> > The charge of Neglect of Duty is a serious charge under the Code of Conduct. To be convicted of this charge, it must be shown that:
> >
> > > The member was required to perform a duty, and the member failed to perform this duty because of neglect, or did not perform the duty in a prompt or diligent manner.
> >
> > Once proven, the member, to avoid discipline, must then show that:
> >
> > > [The member] had a lawful excuse for not performing the duty in the prescribed manner.
>
> The specific allegation is that the two officers failed to immediately report to their dispatcher the results of their investigation and in particular the recovery of the pool cue and baseball bat. The implication is that if these items had been reported that it might have assisted the investigation of what happened to the unconscious man found earlier in the same area. The issue here is whether or not there was a duty on Constables Hewitt and Devine to report their findings to their dispatcher. Further if such a duty existed, whether or not their failure to meet it was based on a lawful excuse.
>
> The duties imposed on police officers can arise from a number of sources. These include statute, common law rules and orders. That being said, it is evident that police officers are to be diligent in the investigation of crimes and apprehending criminals. In *McGuire and Toronto Police Service*, it was noted that:
>
> > Diligence is defined in the Oxford English Dictionary as being "the care and attention due from a person in a given situation." The Random House Dictionary defines diligence as "the constant and earnest effort to accomplish what is undertaken; persistent exertion of body and mind".

> In situations where there is a clear or explicit rule to be followed then it is relatively simple to determine the precise steps to be taken diligently perform an obvious duty. An example would be the directive to compete reports for received property.
>
> However, there does not appear to be a rule or directive requiring officers in Toronto to advise their dispatcher of the results of their investigation of every call. That suggests that some reasonable exercise of judgement or discretion is anticipated. As was stated in *Mousseau and Toronto Police Service:*
>
> > The reasonableness of an officer's conduct must be examined in light of the circumstances as they exist at a particular time. An officer is expected to use discretion and judgement in the course of his duties on many occasions. The police officer's discretion or judgement ought not to be examined scrupulously by the benefit of hindsight, but it is essential to examine the circumstances under which the officer exercised discretion or independent judgement to see to what extent discretion was warranted.

Mr. Dubois submitted that in this case, the officers failed, due to neglect, to perform a lawful duty without a lawful excuse to not perform it. In the matter of *Neild v. Ontario Provincial Police*, 2018 ONCPC 1 (CanLII), the Commission addressed the legal test for a finding of neglect of duty, finding the hearing officer accurately stated the law. In that matter, the hearing officer determined that to make a finding of guilty, the officer must have failed to perform a duty they were required to perform due to neglect or did not perform the duty in a prompt and diligent manner. The failure must include a degree of willfulness which would make the matter cross the line from a performance issue to one of misconduct. Once proven, to avoid discipline, the officer must show that they had a lawful excuse for not performing the duty in the prescribed manner.

Mr. Dubois submitted there are parallels between *Neild* and this case. In *Neild*, the Commission noted:

> The last issue considered by the Hearing Officer was whether the appellant's neglect amount to misconduct or was the result of a performance issue. She wrote that the appellant's "unfounded and premature belief" that Mr. Roach "unfortunately just died in the snow" was in contrast to the key messaging to all officers that a death investigation may evolve into a homicide [investigation].

Mr. Dubois cited the matter of *Moore v. Ontario Provincial Police*, 2088 ONCPC 2 (CanLII) in support of the assertion that an officer cannot "pass the buck," officers must ensure duties are fulfilled.

Mr. Dubois submitted case law indicating that clear policy direction is not required for a finding of neglect of duty, the reasonableness of the officer's conduct must be examined in the circumstances that exist at a particular time.

In this case, in addition to neglect of duty, the officers are charged with discreditable conduct, contrary to Subsection 2(1)(a)(i) of the Conduct of Conduct. Mr. Dubois submitted there are no known cases under this section to provide guidance to the tribunal. The are some cases under what Mr. Dubois referred to as a "sister section," Subsection 2(1)(a)(ii) which can be of some assistance.

Mr. Dubois submitted the test for discreditable conduct under these subsections is different than the other subsections of discreditable conduct. In the matter of *Drennan and Hamilton-Wentworth Regional Police Service*, 1996 CanLII 17298 (ON CPC), the Commission noted:

> The primary provision against which the Appellant's conduct is assessed found at section (1)(a)(i.2) of the Code of Offences states as follows:
>
> 1) Any chief of police or other police officer commits an offence against discipline if he or she is guilty of,
>
> a) Discreditable conduct, that is to say, if he or she,
>
> (i.2) uses profane, abusive or insulting language that relates to a person's race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, or handicap.
>
> The source for this wording is to be found in sections 5, 7 and 10 of the Human Rights Code. Section 5 declares that:
>
> 1) Every person has a right to equal treatment with respect to employment without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, record of offences, marital status, family status or handicap.
> 2) Every person who is an employee has a right to freedom from harassment in the workplace by the employer or agent of the employer or by another employee because of race, ancestry, race of origin, colour, ethnic origin, citizenship, creed, age, record of offences, marital status, family status or handicap….
>
> It is our conclusion that section (1)(a)(i.2) of the Code of Offences must be interpreted having regard not only to section 7(2) of the *Human Rights Code* but section 5(2) as well.

Mr. Dubois submitted that the Commission in *Drennan* indicated it is permissible to pick up language from the *Human Rights Code* and it is reasonable to refer to it for the purpose of relevant provisions and whether clear and convincing evidence exists under this *Act*. Mr.

Dubois submitted that in this case, I must consider whether discrimination existed which will require the analysis of case law in that area. In addition, to the preamble in the *Human Rights Code*, Mr. Dubois noted that Section 1 states:

> Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

Mr. Dubois submitted I must consider Section 1, and the oath taken by all police officers in the Province of Ontario which reads as follows:

> I solemnly swear (affirm) that I will be loyal to Her Majesty the Queen and to Canada, and that I will uphold the Constitution of Canada and that I will, to the best of my ability, preserve the peace, prevent offences and discharge my other duties as (insert name of office) faithfully, impartially and according to law. So help me God. (Omit this line in an affirmation.) or, I solemnly swear (affirm) that I will be loyal to Canada, and that I will uphold the Constitution of Canada and that I will, to the best of my ability, preserve the peace, prevent offences and discharge my other duties as (insert name of office) faithfully, impartially and according to law. So help me God. (Omit this line in an affirmation.

Mr. Dubois noted impartiality is essential as per the *Police Services Act* and the *Human Rights Code*. In the matter of *Biring v. Peel Regional Police Service*, 2021 ONCPC 2 (CanLII) the Commission addressed the issue of whether the hearing officer applied the correct test for discreditable conduct under section 2(1)(a)(ii) and stated:

> Again, in our view, on a fair reading of the decision of the Hearing Officer, for reasons that are fully articulated, he concluded that the words used by the appellant were insulting as that wordterm is used in s. 2(1)(a)(ii) of the Code. There was no need for the prosecution to establish that the appellant intended the words to be insulting as intention is generally irrelevant when considering discriminatory words or actions. Nor do we accept that the Hearing Officer was required to consider the appellant's "legitimate purpose or good faith" in deciding whether the appellant's language constituted Discreditable Conduct. If intention is irrelevant to discriminatory conduct, so is a suggestion that the insulting words were said in good faith. The words spoken were discriminatory in nature and therefore offensive and insulting.
>
> The appellant submitted that the Hearing Officer was required to consider the potential damage to the reputation and image of the police service when deciding if the conduct complained of amounted to Discreditable Conduct, citing *Saxon v. Amherstburg Police Service.* The Commission has generally not required that the objective test be applied to all categories of prescribed discreditable conduct under s. 2(1)(a), except for a charge under s. 2(1)(a)(xi) which requires the conduct to "likely to bring discredit upon

the reputation of the police force." In *Mulville and Azaryev and York Regional Police*, the Commission set out the test as follows:

> The objective test would require that the Hearing Officer place a dispassionate reasonable citizen fully apprised of the same facts and circumstances, aware of the applicable rules and regulations, in the same situation to assess whether the officer's language was discreditable

However, we note that the Hearing Officer did write that the conduct of the appellant was "objectively offensive to community standards" which, in our view, would certainly be likely to bring discredit to the reputation of the Peel Regional Police Service. Once it is established that the insulting and discriminatory words were spoken it would be axiomatic that the words from a senior officer in charge of recruiting would be likely to bring discredit to the reputation of the Peel Regional Police Service.

Mr. Dubois submitted the objective test which is to be applied in matters of alleged discreditable conduct under section 2(1)(a)(xi), does not apply to section 2(1)(a)(ii).

Mr. Dubois submitted the matter of *McKay v. Toronto Police Services Board*, 2011 HRTO 499 (CanLII) to illustrate how decide if discrimination existed in this case. The Human Rights Tribunal of Ontario stated that the issues to be decided are:

- Has the complainant established a prima facie case of discrimination? In the present Complaint, the nexus between the alleged discrimination and the protected ground of race is the primary question.
- If the complainant establishes a prima facie case, can the personal respondent demonstrate rational and credible justification(s) for the alleged differential treatment?
- If so, can the complainant refute the personal respondent's justification(s) as flawed and/or pretextual?

Mr. Dubois submitted the first two parts are clearly evident, it is the third test which is contested; whether race was a factor in the alleged mistreatment. Mr. Dubois noted that often, there is no direct evidence of racism, stereotyping, and discrimination; it is often subtle. In the matter of *R. v Brown,* 2003 CanLII 5142 (ON CA), the Court stated:

> A racial profiling claim could rarely be proven by direct evidence. This would involve an admission by a police officer that he or she was influenced by racial stereotypes in the exercise of his or her discretion to stop a motorist. Accordingly, if racial profiling is to be proven it must be done by inference drawn from circumstantial evidence.

Mr. Dubois submitted that this is not a racial profiling case, but I am permitted to undertake a similar analysis. In the matter of *Shaw v. Phipps*, 2010 ONSC 3884 (CanLII), the Court stated:

> The applicants assert that the Tribunal essentially used the concept of "unconscious discrimination" to make a finding of discrimination in the absence of supporting

evidence. We disagree. Many discrimination cases, such as this case, do not involve direct evidence that a complainant's colour or race was a factor in the incident in question. A tribunal must draw reasonable inferences from proven facts. That is exactly what the Tribunal did in this case. The Tribunal correctly outlined the principles that apply in cases involving an allegation of racial discrimination. The applicants do not dispute that these principles apply to the decision-making process:

a) The prohibited ground or grounds of discrimination need not be the sole or the major factor leading to the discriminatory conduct; it is sufficient if they are a factor;
b) There is no need to establish an intention or motivation to discriminate; the focus of the enquiry is the effect of the respondent's actions on the complainant;
c) …
d) There need be no direct evidence of discrimination; discrimination will more often be proven by circumstantial evidence and inference; and
e) Racial stereotyping will usually be the result of subtle unconscious beliefs, biases and prejudices.

Mr. Dubois submitted the *Gauthier* case is not binding on this tribunal, it was a decision of a hearing officer and it only included neglect of duty, not discreditable conduct. Mr. Dubois submitted that Staff Sergeant Harrison essentially admitted to misconduct in his cross-examination. He noted that it is uncontested evidence that Staff Sergeant Harrison was the lead, and supervising officer. The Agreed Statement of Facts show that Sergeant Whipple was part of the investigative team from start to finish. Mr. Dubois conceded Sergeant Whipple may not have had a central role, but he cannot abdicate his role and responsibility as a police officer.

Mr. Dubois submitted that all three investigating officers had the same duties under the *Police Services Act,* the fact that Sergeant McKever is not facing Code of Conduct allegations is not relevant. Mr. Dubois submitted that as the supervising officer, Staff Sergeant Harrison made assumptions about how Stacey DeBungee died; the tunnel vision he employed at the scene tainted the remainder of the investigation. Mr. Dubois submitted those assumptions were based on discriminatory grounds and stereotyping; if an Indigenous man with previous police dealings for alcohol offences is found dead in the water, he must have been drunk, rolled into the river, and drowned.

Mr. Dubois submitted Stacey DeBungee's Indigenous status played a factor in how the officers conducted the sudden death investigation. The officers knew the deceased person was Indigenous and based on stereotyping, they decided it was nonsuspicious; it caused them to neglect their duties and decide before the post-mortem examination that the death was nonsuspicious.

Mr. Dubois submitted the officers released the scene in advance of the post-mortem because it was not considered to be a crime or a potential crime scene. That prejudgment, and the media release just a few hours into the investigation are supportive of his stereotyping assertion. He noted that Staff Sergeant Harrison knew that Sergeant McKever did not conduct a canvass, he merely looked for cameras on the exterior of nearby businesses and he did not ensure that the scene was videotaped.

Mr. Dubois submitted that the officers did not read the reports and found no urgency in locating Mr. Sapay because their minds were closed to foul play.

Mr. Dubois noted that the second media release was also disseminated prior to the post-mortem and at the next of kin meeting and the initial meeting with Brad DeBungee, the officers indicated there was no evidence of foul play.

Mr. Dubois submitted that Staff Sergeant Harrison denied in his testimony that he ever saw or approved the second media release, but in his interview with the OIPRD stated that Mr. Adams "probably did send it to me for approval." Mr. Dubois submitted Staff Sergeant Harrison's testimony is not credible; the media release would not be disseminated without approval, and it is more likely than not that it would have been approved by Staff Sergeant Harrison just as he alluded to in his interview.

Mr. Dubois submitted that the sudden death scene should have been secured until after the post-mortem according to the sudden death policy and it should have been treated as a homicide because the cause of death was unexplained. Mr. Dubois noted that in her statement to the OIPRD, Staff Sergeant Kaucharik was of the opinion on October 20, 2015, based on a conversation had with Staff Sergeant Harrison, that the death did not appear criminal in nature. Mr. Dubois noted that in his testimony, Staff Sergeant Harrison took a different position, stating that he would not have approved the second media release because it made a conclusion that the death was non-criminal, a position that he himself had not yet come to.

Mr. Dubois submitted all three officers had the same information after the next-kin-notification which confirmed their initial stereotypes and discriminatory assumptions prior to the post-mortem. Consequently, no further investigation was conducted; their biases made them conclude there was no foul play. Mr. Dubois noted that if the officers conducted interviews of the people at the next of kin meeting, they would have likely learned all the information that Mr. Perry ultimately uncovered; the officers neglected their duties and Staff Sergeant Harrison failed to supervise his subordinates.

Mr. Dubois submitted the officers' inactivity was not an oversight, it was neglectful behaviour due to stereotypes and discrimination based on Stacey DeBungee's Indigenous status.

Public Complainant Submissions

Ms. James submitted that the public complainants support the submissions of the prosecution. Ms. James submitted the officers' defence is based on a "pass the buck" mentality, but this hearing is based on accountability for alleged officer misconduct. She submitted Staff Sergeant Harrison and Sergeant Whipple said they kept an open mind about the nature of the investigation, but they did not conduct a thorough investigation.

Ms. James noted that Mr. Butt submitted the *Gauthier* case should be used for reference in findings of this case. She submitted that in *Gauthier*, the policy that was not adhered to, was not prescriptive, the officer was found to have exercised discretion in good faith. She noted that if I am to consider good faith as an element, I ought to note at the onset the officers' minds were set, good faith is not applicable.

Ms. James submitted Brad DeBungee told the OIPRD that he felt like he was getting brushed off by the Thunder Bay Police Service, which is the bias and discrimination set out in the Broken Trust report. Ms. James stated the officers' inaction was beyond systemic, it was also laziness. The officers had access to the reports but chose to not read them because they had already concluded how Stacey DeBungee died; had they actually been still investigating, they would have read the reports, instead they did nothing.

Ms. James submitted the testimony of Staff Sergeant Harrison and Sergeant Whipple related to their work ethic with the Indigenous community ought to receive limited weight, it was just their version, and they did not have an understanding of what systemic racism is. Ms. James noted Staff Sergeant Harrison trains other officers in Major Case Management and did not even take the time to read the Broken Trust report. She submitted Sergeant Whipple did not read it either, their testimony about caring about the Indigenous community then cannot be credible.

Ms. James noted that neither officer took steps to locate Mr. Sapay when the BOLO flag had no results, the conclusion must be that they did not care because they had already concluded how Stacey DeBungee died.

Ms. James submitted the next of kin meeting confirmed the officers' suspicions that an Indigenous man was drinking by the river and fell in. She stated that the problem with the media release is that they did not know how he died, they did not know that there was not a serial killer responsible, they are supposed to be truthful in a media release. Any suggestion that the initial media release was the perfect balance of public safety and informing the public defies logic, the post-mortem was pending and they did not know how Stacey DeBungee died.

Ms. James submitted that Sergeant Whipple is a police officer, he cannot shift blame, he has a formal responsibility to conduct a proper investigation, not a neglectful one based on discrimination and bias.

Ms. James submitted Stacey DeBungee's Indigenous status was front and centre from the onset of the investigation, the officers assumed he was drunk and rolled in the river based on no evidence to support that position. They had no evidence he had been drinking, no evidence of drinking at the scene, and no evidence as to how Stacey DeBungee ended up in the river. Ms. James stated their actions or lack thereof support Mr. Leonard's concern that the police assumed Stacey DeBungee was "just another drunken Indian."

Ms. James submitted the *Ontario Human Rights Code* applies to the conduct of police officers. Ms. James submitted that I ought to be guided by the *Human Rights Code* preamble in terms of how I look at racism in this case. It states:

> Whereas recognition of the inherent dignity and the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world and is in accord with the Universal Declaration of Human Rights as proclaimed by the United Nations;
>
> And whereas it is public policy in Ontario to recognize the dignity and worth of every person and to provide for equal rights and opportunities without discrimination that is contrary to law, and having as its aim the creation of a climate of understanding and mutual respect for the dignity and worth of each person so that each person feels a part of the community and able to contribute fully to the development and well-being of the community and the Province;
>
> And whereas these principles have been confirmed in Ontario by a number of enactments of the Legislature and it is desirable to revise and extend the protection of human rights in Ontario…

Ms. James submitted a Human Rights Tribunal of Ontario decision, *Phipps v. Toronto Police Services Board*, 2009 HRTO 877 (CanLII), where the adjudicator stated:

> The relevant principles that apply in cases where an allegation of racial discrimination has been raised have been usefully summarized as follows:
>
> a) The prohibited ground or grounds of discrimination need not be the sole or the major factor leading to the discriminatory conduct; it is sufficient if they are a factor;
> b) There is no need to establish an intention or motivation to discriminate; the focus of the enquiry is on the effect of the respondent's actions on the complainant;
> c) The prohibited ground or grounds need not be the cause of the respondent's discriminatory conduct; it is sufficient if they are a factor or operative element;

d) There need be no direct evidence of discrimination; discrimination will more often be proven by circumstantial evidence and inference; and
e) Racial stereotyping will usually be the result of subtle unconscious beliefs, biases and prejudices.

In this case, as in many cases alleging racial discrimination, there is no direct evidence that race was a factor in the officer's decision to take the actions that he did. As a result, the issue of whether the officer's actions amount to racial discrimination in violation of the Code falls to be determined in accordance with the following well-established principles applicable to circumstantial evidence cases.

1) Once a prima facie case of discrimination has been established, the burden shifts to the respondent to provide a rational explanation which is not discriminatory.
2) It is not sufficient to rebut an inference of discrimination that the respondent is able to suggest just any rational alternative explanation. The respondent must offer an explanation which is credible on all the evidence.
3) A complainant is not required to establish that the respondent's actions lead to no other conclusion but that discrimination was the basis for the decision at issue in a given case.
4) There is no requirement that the respondents' conduct, to be found discriminatory, must be consistent with the allegation of discrimination and inconsistent with any other rational explanation.
5) The ultimate issue is whether an inference of discrimination is more probable from the evidence than the actual explanations offered by the respondent.

Ms. James submitted that there is a different standard of proof in a Human Rights tribunal but noted the same principles can be relied upon in this case; racial stereotyping created tunnel vision and affected how the officers' conducted their investigation into the sudden death of Stacey DeBungee.

Ms. James submitted that the Court's comments in *R. v. Williams*, 1998 CanLII 782 SCC [1998] 1 SCR 1128 are applicable to this matter despite the fact they were made in relation to jury selection. The Court stated:

> To suggest that all persons who possess racial prejudices will erase those prejudices from the mind when serving as jurors is to underestimate the insidious nature of racial prejudice and the nature that underlies it. As Vidmar, *supra*, points out, racial prejudice interfering with jurors' impartiality is a form of discrimination. It involves making distinctions on the basis of class or category without regard to individual merit. It rests on preconceptions and unchallenged assumptions that unconsciously shape the daily behaviour of individuals. Buried deep in the human psyche, these preconceptions cannot be easily and effectively identified and set aside, even if one wishes to do so.

> For this reason, it cannot be assumed that judicial directions to act impartially will always effectively counter racial prejudice.

Ms. James submitted Staff Sergeant Harrison and Sergeant Whipple, based on prejudice stereotyping and racial discrimination decided Stacey DeBungee was a drunk Indigenous person who rolled into the river and drowned.

Ms. James noted that the coroner indicated to the OIPRD that the officers had not made up their minds, that the officers were going to continue their investigation, but they did not because they had already decided. In that interview, the coroner informed the OIPRD that Stacey DeBungee was known to be a heavy drinker and that the officers were going to investigate as to whether he had just fallen in. Ms. James noted Stacey DeBungee was not known to the coroner so the information about him being a drinker must have come from the investigating officers. Ms. James submitted Stacey DeBungee being intoxicated and rolling into the river was their working theory. She submitted, their work was appalling, they gave little effort to determine how Stacey DeBungee ended up in the river.

Ms. James submitted the OIPRD completed a systemic review into the Thunder Bay Police Service was a direct result of this complaint. The Broken Trust report was released in 2018. Ms. James noted that the findings were not challenged but Mr. Butt took the position I ought to give it little weight similar to *Gauthier*.

Ms. James submitted the difference is the review in *Gauthier* was an overarching review of how missing person investigations were handled, whereas the Broken Trust report is about racism in the Thunder Bay Police Service, the very issue that is before this tribunal. Consequently, Ms. James submitted the report is very relevant and urged me to rely upon it.

Ms. James submitted the second media release was consistent with what Staff Sergeant Harrison was thinking at the time. No one asked any questions about the alcohol, if anyone was serving to him, how much had he consumed etcetera, the officers were content with their working theory.

In her material, Ms. James included the OIPRD report dated February 2020 titled, “One Year After Broken Trust.” Ms. James submitted that this report validates the Broken Trust report because the Thunder Bay Police Service acknowledged systemic racism existed and took steps to implement OIPRD recommendations.

Ms. James submitted that if I am to consider good faith as a defence in this matter, I ought to consider the Commission’s comments in *Bennet (Re),* 2014 ONCPC 2504 (CanLII):

> The Board of Inquiry in *Girard v. Delaney*, supra, was very direct in response to this, concluding that while good faith can be considered as part of the assessment the test

is objective with a high level of importance placed on the requirements of the applicable "rules and regulations". It was held that:

> An officer's neglect of duty, without any element of bad faith or recklessness, can [still] bring discredit upon the reputation of the police force.

Ms. James submitted that in this case, Staff Sergeant Harrison and Sergeant Whipple failed to take adequate notes, failed to review reports relevant to the investigation, and failed to receive additional information from Mr. Perry. It is consistent with having tunnel vision, with their working theory, that Mr. DeBungee was another drunken Indian who passed out and rolled into the river where he drowned; the actions amount to misconduct as alleged.

Defence Submissions in Reply

Mr. Butt submitted something being a possibility is very different than it being the only thing it could be. In this instance, the officers considered Stacey DeBungee rolling into the river and drowning a possibility, but it was never considered the only possible explanation. Mr. Butt submitted there were many possibilities available, and the evidence never permitted the drawing of conclusions by the officers.

Mr. Butt noted that tunnel vision is drawing conclusions prematurely while the opposite is considering all possibilities and seeing where the evidence leads.

Mr. Butt submitted the standard for discreditable conduct is as he has set out, there are no cases that suggest I ought to take a different approach considering subsection 2(1)(a)(i); it falls under the umbrella of discreditable conduct. Mr. Butt submitted that Mr. Dubois' position is based on an inappropriate reliance of a different section and premised on the absence of any authority that says it ought to be considered differently.

Mr. Butt noted that the *McKay* case illustrates that Human Rights tribunal cases have a different, and lower standard than this tribunal. Mr. Butt submitted that it is the totality of the evidence that must convince me of guilt based on the standard of clear and convincing evidence. However, if there is to be a finding based on singular information, that information, standing on its own must reach the standard of clear and convincing evidence.

Mr. Butt questioned why the officers would demonstrate any type of discrimination in this particular case when they have been so committed to Indigenous issues in all their other cases; there is no motivation for racist intent in this case. Mr. Butt submitted the officers' kept an open mind and followed the evidence.

Analysis

During this hearing, reference was made to a Coroner's Inquest that had commenced just prior to the date of this alleged misconduct. Between 2000 and 2011, seven First Nations youths died while they were in Thunder Bay attending school. The death of each of the students was investigated by the Thunder Bay Police Service. Five of the students were found in the McIntyre or Kaministiquia Rivers. Indigenous communities raised serious questions about how the youths ended up in the rivers and the quality of the missing persons and death investigations. The Broken Trust report noted:

> A Coroner's Inquest into the Deaths of Seven First Nations Youths was held in Thunder Bay between October 5, 2015, and June 28, 2016.

The nature and the dates of the Inquest are relevant to this hearing in the sense that it was ongoing at the time of the Stacey DeBungee sudden death investigation and the manner in which he died, being found in the McIntyre River is analogous.

Following the completion of the evidence, but in advance of submissions, I sent the following email to counsel on June 13, 2022:

> For your consideration in submissions…
>
> My poling experience includes, approximately:
>
> - eight years in crime units as a detective constable;
> - two years as a detective sergeant supervising a crime unit;
> - two years as a detective staff sergeant supervising multiple detective sergeants and their respective teams; and
> - eight years as a detective inspector, major case manager responsible for managing files that met the definition of major case as per the Manual.
>
> This matter could have been capably heard by a hearing officer without this background, having experience investigating sudden deaths and homicides at all levels was not a prerequisite to hear this matter. However, this is my background. I make mention of this simply to make Counsel aware. As you know, a hearing officer is permitted to rely on their own professional experience, but I invite Counsel to make submissions on this issue, but only if you feel it necessary, in terms of the perils (if any) of relying on my experience in this area.

Counsel did not make submissions to caution me about relying on my own experience as a criminal investigator. During the hearing, it was suggested that the Thunder Bay Police Service is a mid-size municipal police service with personnel limitations that other, larger police services in Ontario may not experience. It is worth noting that I spent six years as a detective constable with the Peel Regional Police Service in the 1990's and was with the Ontario

Provincial Police when I was a major case manager, but for several years in between, I worked for the Haldimand-Norfolk Police Service, a small municipal police service. Consequently, I believe I am well situated to view the roles, responsibilities, and limitations if any, of members of the Thunder Bay Police Service, through an appropriate lens. I have experience with small and large police services, investigating sudden deaths and homicides at multiple ranks, with responsibilities ranging from those assigned to a detective constable, to major case manager as a detective inspector.

I will be cautious to not apply unrealistic expectations, and careful to not rely on hindsight; the actions of the officers must be considered based on what was known, and common practices at the time.

I will first discuss the law and how it applies to the allegations in this matter followed by an analysis of the evidence as it relates to neglect of duty and discreditable conduct.

The Law

Staff Sergeant Harrison and Sergeant Whipple are each charged with one count of neglect of duty and one count of discreditable conduct. Collectively, the allegations are that without lawful excuse, they failed to perform their duty as police officers promptly and diligently due to Stacey DeBungee's Indigenous status. Mr. Butt submitted that if neglect of duty is not established, then the discreditable conduct must fall. I can see how on its surface it would appear so, but it is feasible that if neglect of duty has not been proven, it could still be made out that one or both officers failed to treat or protect Stacey DeBungee or others, equally and without discrimination. I must look at all of the evidence independently to determine if the facts in issue have been met based on the applicable standard of proof.

In matters before the Human Rights Tribunal of Ontario, the standard of proof is less than that of a *Police Services Act* hearing such as this. In *Jacobs* the Court noted:

> As part of its analysis [in *Penner*], the court addressed, at para. 60, the different standards of proof in civil actions and *Police Services Act* hearings:
>
> > As the Court of Appeal recognized, because the *Police Services Act* requires that misconduct by a police officer be "proved on clear and convincing evidence" (s.64(10)), it follows that such a conclusion might, depending upon the nature of the factual findings, properly preclude relitigation of the issue of liability in a civil action where the balance of probabilities — a lower standard of proof — would apply. However, this cannot be said in the case of an acquittal. The prosecutor's failure to prove the charges by "clear and convincing evidence" does not necessarily mean that those same allegations could not be established on a balance of probabilities. Given the different standards of proof…

> Penner was binding authority on the Divisional Court and it erred in distinguishing it on the basis that all parties in that case accepted that clear and convincing evidence was a higher standard of proof…Counsel for the respondents fairly concede that if the Supreme Court determined the issue of the standard of proof under the *Police Services Act* in *Penner*, the appeal must be allowed and it is unnecessary to engage in a statutory interpretation of s. 84(1). In my view, we are bound by the Supreme Court's statement in *Penner* that the standard of proof in *Police Services Act* hearings is a higher standard of clear and convincing evidence and not a balance of probabilities.

To me, clear and convincing evidence goes well beyond a balance of probabilities, yet less than the criterion found in the criminal court context of beyond a reasonable doubt. I find that the evidence must be so clear, so reliable, and so convincing, to persuade me the allegations are true, and the facts in issue, satisfied.

With the standard of proof determined, it is important to consider what facts are necessary to make a finding of guilty of neglect of duty and discreditable conduct. I will first consider the definition of neglect of duty.

In the matter of *Neild*, the Commission found the hearing officer accurately addressed the legal test for a finding of guilty in a neglect of duty case. The Commission stated:

> The Hearing Officer adopted the following quotation from the Commission's decision in *Gottschalk v. Toronto Police Service*, 2003 CanLII 85796 (ONCPC) in her analysis of what constituted neglect of duty:
>
> > The charge of neglect of duty is a serious charge under the Code of Conduct. To be convicted of this charge, it must be shown that:
> >
> > > The member was required to perform a duty, and the member failed to perform this duty because of neglect, or did not perform the duty in a prompt and diligent manner.
> >
> > Once proven, the member, to avoid discipline, must show that:
> >
> > > [The member] had a lawful excuse for not performing the duty in the prescribed manner.
> >
> > …It is not an absolute offence…there must be either "wilfulness" or a degree of neglect which would make the matter cross the line from a mere performance consideration to a matter of misconduct.
>
> The Hearing Officer also cited the following passage from the decision in *Mousseau and the Metropolitan Toronto Police Force*, 1981 CanLII 3042 (ONCPC):
>
> > The reasonableness of an officer's conduct must be examined in light of the circumstances as they exist at a particular time. An officer is expected to use

> discretion and judgment in the course of his duties on many occasions. The police officer's discretion or judgment ought not to be examined scrupulously by the benefit of hindsight, but it is essential to examine the circumstances under which the officer exercised discretion or independent judgment to see what discretion was warranted.

In this case, to make a finding of guilty of neglect of duty, I must be satisfied on clear and convincing evidence, that the officer(s) were required to perform a duty, that without lawful excuse the duty was either wilfully not performed, or was not performed diligently or promptly. The negligence must be more than a mere performance issue to amount to misconduct. When considering the evidence, I must refrain from applying the benefit of hindsight, I must consider the circumstances under which the officer(s) exercised their discretion or judgment.

There was dispute about what is required to make a finding of guilty in relation to the charge of discreditable conduct, specifically, subsection 2(1)(a)(i) of the Conduct of Conduct. Counsel agreed, they were unable to find cases in Ontario under this particular section.

Mr. Butt submitted that the test for discreditable conduct is well established, it is primarily an objective test, incorporating a subjective element of good faith. It requires an assessment of whether the impugned actions would bring discredit upon the service in the eyes of the reasonable, impartial, and fully informed person.

In the matter of *Wells and Cornwall Police Service*, 2021 ONCPC 13 (CanLII), the Commission noted:

> The appellant acknowledged in oral argument before us that the Hearing Officer did set out in his decision the proper test for discreditable conduct from *Galassi*, which stated the following:
>
> > The test is primarily an objective one.
> >
> > The Board [referring to the former Boards of Inquiry] must assess the conduct of the officer by the reasonable expectations of the community.
> >
> > In determining the reasonable expectations of the community, the Board may use its own judgment, in the absence of evidence as to what the reasonable expectations are. The Board must place itself in the position of the reasonable person in the community, dispassionate and fully apprised of the circumstances of the case.
> >
> > In applying this standard, the Board should consider not only the immediate facts surrounding the case but also any appropriate rules and regulations in force at the time.

> Because of the objective nature of the test, the subjective element of good faith (referred to in the *Shockness* case) is an appropriate consideration where the officer is required by the circumstances to exercise his discretion.

In *Tapp and Ontario Provincial Police*, 2018 ONCPC 16 (CanLII), the Commission stated:

> In our view, the Hearing Officer correctly stated the law as to discreditable conduct. Two decisions cited by the respondent support this conclusion. In *Constable W.D. Silverman v. Ontario Provincial Police*, 1997 CanLII 22046 (ON CPC) the Commission wrote:
>
> > …the jurisdiction of the *Police Services Act* is not limited to on-duty activities and any officer whose activities off-duty bring discredit upon the reputation of the Police Service is subject to discipline by the Service. The measure used to determine whether conduct has been discreditable is the extent of the potential damage to the reputation and image of the Service should the action become public knowledge.
>
> In the case of *Susan Mancini and Constable Martin Courage of the Niagara Regional Police Service*, 2004 CanLII 76810 (ON CPC) the Commission wrote:
>
> > The concept of discreditable conduct covers a wide range of potential behaviours. The test to be applied is primarily an objective one. The conduct in question must be measured against the reasonable expectation of the community. It is not necessary to establish actual discredit.
>
> The appellant cited the decision in *Gallant v. Ontario Provincial Police*, 2017 ONCPC 16 (CanLII) where the Commission wrote:
>
> > The appellant accepts that the Hearing Officer correctly stated the test for discreditable conduct. The Hearing Officer wrote “The test for discreditable conduct is primarily an objective one and can be measured in asking this question: Would a reasonable person in the community, dispassionate and fully apprised of the circumstances of the case perceive the statements as discreditable?”
>
> In our view, the Hearing Officer who referred both to *Silverman* and *Mancini* correctly stated the law relating to discreditable conduct…

Based on these cases, and in adherence of the submissions of Mr. Butt, in assessing whether the conduct is discreditable, I must determine whether a reasonable person in the community, fully aware of the facts, would find that the conduct would likely discredit the reputation of the Thunder Bay Police Service if it were to become public knowledge. Evidence was not presented specific to the expectations of the community so I would have to use my own judgement and place myself in the position of the reasonable person.

Mr. Dubois submitted this is not the test to be utilized in this instance, however. He submitted that the test for discreditable conduct as outlined by Mr. Butt, is specific to the most common wording, Subsection 2(1)(a)(xi) which includes the following language, "likely to bring discredit upon the reputation of the police force of which the officer is a member." The discreditable conduct offences in *Tapp* and *Wells* related to Subsection 2(1)(a)(xi).

Mr. Dubois relied upon the Commission's comments in *Biring*, related to Subsection 2(1)(a)(ii), which in part, noted:

> The appellant submitted that the Hearing Officer was required to consider the potential damage to the reputation and image of the police service when deciding if the conduct complained of amounted to Discreditable Conduct, citing *Saxon v. Amherstburg Police Service.* The Commission has generally not required that the objective test be applied to all categories of prescribed discreditable conduct under s. 2(1)(a), except for a charge under s. 2(1)(a)(xi) which requires the conduct to "likely to bring discredit upon the reputation of the police force." In *Mulville and Azaryev and York Regional Police*, the Commission set out the test as follows:
>
> > The objective test would require that the Hearing Officer place a dispassionate reasonable citizen fully apprised of the same facts and circumstances, aware of the applicable rules and regulations, in the same situation to assess whether the officer's language was discreditable.

I agree with the position taken by Mr. Dubois, to make a finding of guilty, it is not necessary to determine whether a reasonable person in the community, fully aware of the facts, would find that the conduct would likely discredit the reputation of the Thunder Bay Police Service if it were to become public knowledge. However, I find it difficult to think of a situation where an officer could be found guilty of behaving in a manner where he/she failed 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, which would not discredit the reputation of their employer from the perspective of the fully informed, dispassionate member of the public.

To make a finding of guilty for discreditable conduct in this instance, I must consider whether Staff Sergeant Harrison and/or Sergeant Whipple, failed 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.

To make this assessment, I must be somewhat guided by the *Human Rights Code*. I am very aware that the evidentiary standard in a Human Rights tribunal is far lower than in this *Police Services Act* tribunal, but that does not affect my ability to be guided by principles contained therein.

Mr. Butt submitted Human Rights notions like unconscious bias have no place in this tribunal, it is a fundamental requirement for punishment that there be a blameworthy act; unconscious bias is something we all have in different ways and to different degrees, it is not something that warrants punishment.

Mr. Dubois and Ms. James conceded that there is no overt evidence indicating the officers exhibited discrimination conduct, they may not have verbalized that Stacey DeBungee "was just another drunken Indian who rolled into the river and drowned," but their actions support that assertion. Therefore, to make such a finding, I would have to draw inference(s), that the neglectful behaviour was directly related to Stacey DeBungee's Indigenous status.

I agree with Mr. Butt, an unconscious bias cannot amount to discreditable conduct; how can an officer be held accountable for behaviour that they themselves are not aware of? But what if it is conduct that the officer(s) ought to have been aware of, or the behaviour led to a result which should have alerted the officer(s) to the bias? If an unconscious bias led to conduct that was so obviously unsatisfactory and unacceptable, I find it could be considered misconduct.

In this instance, the underlying reasons for the alleged poor behaviour could be based on an unconscious bias, but the deliberate decisions that followed and that allegedly led to a deficient investigation, should have been very apparent to the officers. Consequently, while officers are not necessarily to be held accountable for an unconscious bias, they must be held accountable for actions that are considered misconduct.

Shaw v. Phipps, 2010 ONSC 3884 (CanLII), was an appeal of an *Ontario Human Rights Commission* decision where a police officer was found to have discriminated against a visible minority. The Court stated:

> The Tribunal cannot make a finding of discrimination based on the concept of "unconscious discrimination" without supporting evidence. However, the Tribunal's decision must be considered in the context of all the facts…
>
> There was no evidence of obvious malice in this case, as may be present in other cases. The Tribunal concluded in the circumstances of this case that the discrimination could be conscious or unconscious…

I note that the officer in that matter was found guilty based on a balance of probabilities in a Human Rights tribunal, which is not the threshold in this matter. However, it is still necessary in this case to consider all the evidence and all the circumstances which existed at the time to assess whether Staff Sergeant Harrison and/or Sergeant Whipple failed to treat or protect persons equally and without discrimination with respect to police services because of Stacey DeBungee's Indigenous status. If so, I must then consider whether it was due to a conscious bias. If neglectful duty was a direct result of a blatant discrimination, the act of discreditable

conduct as alleged in this instance would be made out. If there was neglectful duty that resulted from an unconscious bias, it would be necessary to determine whether the bias was so obvious, that it, and/or the result of that bias, should have been obviously apparent to the officer(s) involved.

As noted, this is a novel area of law related to discreditable conduct. But it simply makes sense to me that if an officer's unconscious bias resulted in misconduct, I must consider whether it was to such a degree that the officer should have been keenly aware of it. I have noted that an officer ought not to be punished for conduct they are not aware of, but I find that an officer can be punished for behaviour that they were not aware of if that behaviour was serious, and to such a degree, that the officer ought to have been obviously aware of its existence and/ or the consequences of it.

Neglect of Duty

The Notice of Hearings as they pertain to the neglect of duty allegations mirror one another with one exception; Staff Sergeant Harrison is identified as the lead investigator and is alleged to have failed to perform his duty in that role. The Particulars of Allegations related to the neglect of duty allegation for each officer, cite specific deficiencies. The Notice of Hearings also include the following language:

> Deficiencies include, but are not limited to…

A series of alleged deficiencies are then listed. I am reluctant to consider deficiencies that are not specifically contained in the Particulars of Allegations; to do so would be unfair to the officers, how can they defend themselves of allegations that are not specifically known? For example, Mr. Dubois made multiple references to Staff Sergeant Harrison's failure to supervise. I questioned him about this assertion as failing to supervise is not listed in the Particulars of Allegations. Mr. Dubois submitted that the responsibility of supervision falls under the umbrella of Staff Sergeant Harrison being identified as the lead investigator. I do not accept this assertion. If the prosecution wished to allege that Staff Sergeant Harrison failed to properly supervise subordinates as part of the neglect of duty allegation, it should have been identified accordingly and listed in the Particulars of Allegations. There was no reason this could not have been accomplished, nine specific allegations are listed and failure to supervise could have easily been included.

In this analysis, I will focus specifically on the deficiencies listed in the Particulars of Allegations. However, one of the particulars alleges "prematurely concluding that the death was non-criminal when the evidence did not support the conclusion that foul play had been excluded." To conduct that analysis will require consideration of the totality of the evidence before the tribunal.

I will first address the neglect of duty allegations that pertain to Sergeant Whipple. Just like Staff Sergeant Harrison, he is alleged to have: not utilized the Major Case Management system; prematurely concluded that the death of Stacey DeBungee was non-criminal when the evidence did not support the conclusion that foul play had been excluded; failed to adequately direct the Forensic Identification Unit which resulted in a lack of documentation and photographs of the scene; failed to ensure forensic examination occurred of the exhibits; approved media releases that indicated the death was “deemed non-criminal” and that “no foul play” was suspected, prior to having the evidence to support this conclusion; failed to formally interview persons who had been in the company of Stacey DeBungee before his death; failed to conduct formal follow up interviews with several witnesses; failed to review reports in the investigative file on an ongoing basis; failed to contact a material witness in a timely manner and only contacting them a long time after the material event.

When I examine these allegations as they pertain to Sergeant Whipple and later, to Staff Sergeant Harrison, I must first consider whether each of the duties were required. There is an obvious distinction in the evidence as it relates to Sergeant Whipple; he was not the lead investigator. The lead investigator has responsibilities not borne by other members of an investigative team. It was clear to me when listening to and after reviewing the evidence, that Sergeant Whipple never had an operational role as a dedicated investigator; on the contrary, it was clear that his role was to merely assist with tasks that required a secondary officer being present.

Sergeant McKever, Staff Sergeant Harrison, and Sergeant Whipple all testified that Sergeant McKever took the initiative to lead the sudden death investigation under the supervision of Staff Sergeant Harrison. The evidence notes that Sergeant Whipple was part of Staff Sergeant Harrison’s investigative team. In my experience, being part of an investigative team does not equate to shared and equal responsibility. Investigators are assigned individual tasks which come with unique responsibilities. An officer in a support role cannot be expected to take on tasks and responsibilities of others; supervisors must supervise, and it is their responsibility to ensure assigned tasks are competed to their level of satisfaction. At no point does the evidence indicate that Sergeant Whipple was given a specific and direct task; all of his assignments were in a support role, assisting Sergeant McKever or Staff Sergeant Harrison.

The evidence showed that Sergeant Whipple was at court, dealing with an unrelated matter, tasked with following up on assignments related to ongoing court obligations when he joined his colleagues at this sudden death call for service. There was discussion in the car about dropping him off at the office prior to attending the scene. This in and of itself speaks volumes to me about the role, or lack thereof, that he was expected to fulfill in the investigation. Of course, things could change leading to an adjusted role, but at no time during the course of this investigation was Sergeant Whipple given a role beyond that of a support person.

The notes of Sergeant McKever do not indicate what his role in the investigation was, or that of Sergeant Whipple, but I accept his testimony that he took the lead. I accept the testimony of Staff Sergeant Harrison that Sergeant McKever was his lead investigator and I accept the testimony of Sergeant Whipple that he was to provide assistance. I also accept Staff Sergeant Harrison's testimony that he remained in charge of the investigation and Sergeant McKever's role as the lead investigator did not change until after the public complaint was received and the investigation was reassigned.

Upon arrival, Sergeant Whipple remained seated in the cruiser, making telephone calls related to his other file while Staff Sergeant Harrison and Sergeant McKever conducted the initial investigation. The Agreed Statement of Facts state that he arrived at the scene approximately 10 minutes after Staff Sergeant Harrison and Sergeant McKever. Considering they arrived in the same car, it suggests the phone calls took him approximately 10 minutes to complete.

When he exited the car, he made some notes about his observations. The notes make no reference to any assignment or conducting any type of active role in the investigation. He testified that he remained at the top of the hill when the body of Stacey DeBungee was in the river and while it was being removed from the water; this is consistent with the role of an assisting detective, not one in a more significant and responsible role.

Section 42 of the *Police Services Act* states:

1) The duties of a police officer include,
    a) preserving the peace;
    b) preventing crimes and other offences and providing assistance and encouragement to other persons in their prevention;
    c) assisting victims of crime;
    d) apprehending criminals and other offenders and others who may lawfully be taken into custody;
    e) laying charges and participating in prosecutions;
    f) executing warrants that are to be executed by police officers and performing related duties;
    g) performing the lawful duties that the chief of police assigns;
    h) in the case of a municipal police force and in the case of an agreement under section 10 (agreement for provision of police services by Ontario Provincial Police), enforcing municipal by-laws;
    i) completing the prescribed training.

Considering the role maintained by Sergeant Whipple, it was not his duty to consider whether to employ the Major Case Management system or to provide direction to the Forensic Identification Unit. I appreciate the submission by Ms. James and Mr. Dubois that Sergeant Whipple is a police officer, bound by section 42 of the *Police Services Act*, but within the context of the Criminal Investigation Bureau, it was not his duty to decide whether to utilize the

Major Case Management system, or to direct the Forensic Identification Unit at the scene. These decisions fall upon the officer in charge of the investigation and the lead investigator, not to Sergeant Whipple who was merely a support officer; he was providing assistance to Sergeant McKever and Staff Sergeant Harrison as needed, he was not in a decision-making position.

I find it more likely than not that Sergeant Whipple was present when matters such as releasing the scene were being discussed or how Stacey DeBungee found himself to be in the river, however I accept his testimony that he did not participate in any decisions being made at the scene; there is no evidence to the contrary and as noted, decisions of this nature were not his responsibility to make. Despite a police officer's oath of office and section 42 of the *Police Services Act* listing a police officer's duties, there is a hierarchy of responsibility at the scene of a sudden death that obviates Sergeant Whipple from duty-bound obligations in this instance considering his role and responsibilities.

I recognize there are occasions where an officer must intervene when he/she observes another officer fail to complete a required duty, or actually commit a deliberate and obvious act of neglectful duty. I do not find that this is one of those occasions. Staff Sergeant Harrison and Sergeant Whipple were very experienced and capable officers who were not dealing with a particularly complex investigation. I do not find that the mistakes made by Staff Sergeant Harrison and Sergeant McKever were of such a degree that it necessitated intervention by Sergeant Whipple, Staff Sergeant Harrison's subordinate.

There is no evidence in support of the assertion that Sergeant Whipple approved either of the two media releases dated October 19, 2015, and October 20, 2015, and he was not copied on the email sent by Mr. Adams in relation to the initial media release.

Sergeant Whipple was directed to make the next of kin notification with Sergeant McKever. He and Sergeant McKever testified that Sergeant McKever as the lead investigator, did most of the communicating while Sergeant Whipple waited in the doorway and became involved in an unrelated matter associated to an adjacent apartment.

I do not accept that it was the duty of Sergeant Whipple to decide if people present at that meeting or at the scene, ought to have been formally interviewed; that was the responsibility of Sergeant McKever as the lead, and ultimately that of Staff Sergeant Harrison as the supervisor.

Similarly, I do not accept that it was the responsibility of Sergeant Whipple to review reports contained in the sudden death investigative file, he did not have an active role, only a supportive role. It was not Sergeant Whipple's responsibility to track down potential witnesses in a timely manner, he was in a supportive role only.

As noted, to amount to neglect of duty, it must be established that an officer intentionally failed to perform a duty that was required. In his role of support officer, I do not find that Sergeant Whipple was duty bound to perform any of the following: decide whether to utilized the Major Case Management system; to direct the Forensic Identification Unit at the scene; to ensure forensic examination occurred of the exhibits; to formally interview persons who had been in the company of Stacey DeBungee before his death; to conduct formal follow up interviews with several witnesses; or to review reports in the investigative file on an ongoing basis. There is no evidence to support the assertion that Sergeant Whipple approved media releases. Because he was not responsible for decisions made in relation to the investigation, I cannot conclude he prematurely determined that the death of Stacey DeBungee was non-criminal.

I turn now to the neglect if duty allegation concerning Staff Sergeant Harrison; his role in the investigating was completely different that that of Sergeant Whipple. The evidence is clear that Staff Sergeant Harrison was in charge of the investigation from beginning to end. Staff Sergeant Harrison, Sergeant McKever, and Sergeant Whipple testified to this fact, and it was noted in the Agreed Statement of Facts.

The Thunder Bay Police Service Criminal Investigation Management Plan stated at the time:

> The Detective in the Criminal Investigation Branch is responsible for all assigned investigations. It is the Detective's responsibility to ensure each incident is investigated to its completion, to assemble all evidence and present it in Court, if charges are laid.
>
> The Detective is also responsible for the training and supervision of the Detective Constables…

The Thunder Bay Police Service policy Part 6, Chapter 12, titled, "Sudden Deaths," stated at the time:

> Investigations into sudden or unexplained deaths and found human remains be considered potential homicide and be undertaken in accordance with the police service's Criminal Investigation Management Plan…
>
> Sudden death includes any death resulting from:
>
> a) homicide
> b) suicide
> c) accident
> d) unexplained or unknown causes.
>
> Police officers involved in all stages of a sudden death investigation shall ensure that the scene and all evidence is protected from disturbance or contamination.

As noted earlier, it is alleged that Staff Sergeant Harrison had duties to perform, and that without lawful excuse he failed to perform those duties promptly and/or diligently, specifically that he failed to properly investigate the Stacey DeBungee sudden death by not treating and investigating it as a potential homicide. Particular deficiencies are then cited.

It is my position that at no time did the investigating officers possess information which should have caused them to determine that Stacey DeBungee died as a result of a homicide. However, the assertion is that because Staff Sergeant Harrison did not treat the death as a potential homicide, he committed neglect of duty. I agree. Staff Sergeant Harrison testified that he always kept an open mind as to what had happened, but the evidence simply does not support that assertion. Had Staff Sergeant Harrison treated the situation as a potential homicide or even as an unknown or undetermined case of death, the investigation would have been much more fulsome. Instead, the investigation conducted into the sudden death of Stacey DeBungee was far less than the bare minimum expected by any investigative standard. To illustrate my position, and to determine whether an inadequate investigation amounts to neglect of duty, I will review each of the investigative deficiencies that are cited in the Particulars of Allegations.

Sudden death not investigated as per the Major Case Management system

The Ontario Major Case Management manual was drafted in October 2004 and was in effect at the time of this matter. Staff Sergeant Harrison testified that he had received training by 2015 and was very familiar with the document and its processes. In fact, he began instructing on the Major Case Management course in 2015. At section one of the Major Case Management manual, the following criteria offences were deemed to be major cases:

a) homicides as defined in subsection 222 (4), Criminal Code of Canada, and attempts;
b) sexual assaults, and all attempts (for the purpose of this standard, is deemed to include sexual interference, sexual exploitation, and invitation to sexual touching);
c) occurrences involving non-familial abductions and attempts;
d) missing person occurrences, where circumstances indicate a strong possibility of foul play;
e) occurrences suspected to be homicide involving found human remains;
f) criminal harassment cases in which the offender is not known to the victim; and,
g) any other case designated as a major case by the Major Case Management Executive Board.

An investigation involving a “major case” requires that the Major Case Management system be employed. All sudden deaths are not criteria offences which warrant the implementation of the Major Case Management system; it is to be utilized for homicides, or where homicide is suspected, or where the circumstances indicate a strong possibility of foul play. I do not agree

with the assertion that it was Staff Sergeant Harrison's duty to implement the Major Case Management system based on the evidence known to him at the time.

Initially, Staff Sergeant Harrison was aware that a body was found in the river which showed no obvious signs of trauma as per the cursory observations of attending paramedics, the police officers on scene, and the coroner in attendance. Staff Sergeant Harrison knew that David Sapay's identification was found at the sudden death scene. Mr. Sapay's identification was certainly an investigative avenue that required investigation and answers, but it did not logically lead to the suspicion of foul play. It is my finding that it also does not amount to a strong possibility of foul play, rather, it allowed for foul play to have occurred.

Similarly, the Thunder Bay Police Service became aware that there may have been an altercation involving Indigenous males at the same location, the night prior to Stacey DeBungee being found. This required further investigation but, in my experience, it falls well short of therefore suspecting foul play.

Mr. Perry, an officer well versed in the Major Case Management manual stated that a situation involving a person found deceased in the water, exhibiting no signs of trauma, with at least one possible witness to be questioned with the post-mortem pending, has the potential to be considered a Major Case. Mr. Perry indicated that all missing persons or found human remains with any hint of suspicion, triggers the implementation of Major Case Management. I agree with his assessment, the information, known and unknown to Staff Sergeant Harrison at the time, allowed for foul play to have occurred.; it had the potential to be considered a major case, but it was not a requirement to implement the Major Case Management system.

I agree that the Major Case Management system could have been implemented, but at no time was the evidence that was known to Staff Sergeant Harrison at time, sufficient enough to cause him to actually develop a strong possibility of foul play. I find it difficult to see the evidence in any other light; it simply did not rise to the level of definitively triggering the implementation of the Major Case Management system.

Forensic Identification Unit - Supervision

It is alleged that Staff Sergeant Harrison failed to adequately direct the Forensic Identification Unit at the scene and failed to ensure exhibits were submitted to the Centre of Forensic Sciences for forensic examination. I found the testimony of Detective Primmer troubling in the sense that she did not even recall Staff Sergeant Harrison being at the scene. I was not provided with a copy of Detective Primmer's notebook entries from October 19, 2015. Her Supplementary Occurrence Report made no mention of any members of the Criminal Investigation Branch being present at the scene, nor is there any mention of why or when the scene was released.

In the Thunder Bay Police Service Part 6 Chapter 12, “Sudden Death” policy under the heading of Identification, it states:

upon arrival at the scene shall:

a) take charge of the immediate scene;
b) conduct forensic examination;
c) ensure positive identification of the victim;
d) take fingerprints of the victim;
e) whenever possible, interact with the coroner in attendance or by phone;
f) arrange for security of the scene if autopsy is to be conducted or if next of kin have not been notified;
g) advise the officer(s) at the scene and the patrol supervisor when scene is no longer to be secured;
h) assist investigating officers to locate information pertaining to next of kin.
i) if an autopsy is to be conducted, place the body in a disposable cadaver bag and seal it.

Detective Primmer testified that at the time of this matter, she was supervised by a Forensic Identification Unit supervisor, a position that she happened to currently hold. Mr. Perry testified that from his perspective, the lead investigator at a sudden death scene has a role in directing the Forensic Identification Unit; the lead investigator is in charge of every aspect of the investigation. I agree. In my experience, at a crime scene or a sudden death scene, the officer in charge of the investigation is responsible for all aspects of the investigation which includes scene management. All other officers have a support role to fulfill. Those individuals, such as members of the Forensic Identification Unit, who are not generally supervised directly by the officer in charge, for the purpose of that specific call for service they do report to the officer in charge of the investigation.

The Major Case Management manual explains this reporting relationship in great detail. It is a principle that has been followed at every crime scene or potential crime scene that I have attended, at least since its implementation in 2004; the principle is not restricted to major cases. In this instance, Staff Sergeant Harrison ought to have been in charge of the scene and the Forensic Identification Unit would have reported to him.

Where the Thunder Bay Police Service policy states that the Forensic Identification Unit shall take charge of the immediate scene, I believe that relates to sudden death incidents where it has been determined that there is no foul play. In my opinion, that is what happened in this instance, the officers immediately determined there was no foul play, and the belief was that the Forensic Identification Unit was therefore in charge of the scene.

It is nonsensical to have the Forensic Identification Unit in charge of a scene where the investigation is being led by the Criminal Investigation Branch, where homicide has not been

ruled out. I have determined that the Major Case Management system need not have been implemented in this case, but best practice scene management principles remained applicable, such as the use of a scene continuity register and how or when the scene ought to have been released, and how it ought to have been managed/supervised. The Major Case Management manual states:

> Only the Major Case Manager, in consultation with the Command Triangle, the Forensic Identification Officer and the Scene Investigator, shall have the authority to release the crime scene after ensuring that all practicable search methods and investigative techniques in relation to the scene have been exhausted.

The same concept ought to have been applied at this scene. Staff Sergeant Harrison ought to have consulted the Forensic Identification Unit asking the question, "what else could be done at this scene that has not been done, what else would be done at the scene if the post-mortem results suggested foul play?" Instead, no one took responsibility for releasing the scene.

Staff Sergeant Harrison testified that if he saw anything that needed to be done by the Forensic identification Unit that was not being done, he would have instructed them to do it such as videotaping the scene. It leads me to conclude he was aware that the scene was his responsibility, but he determined nothing else was required.

Policy instructs the Forensic Identification Unit to "arrange for security of the scene if autopsy is to be conducted or if next of kin have not been notified." Once again, I find this to be the decision of the officer in charge, not the Forensic Identification Unit given the circumstances that existed in this case, but it suggests that the scene ought to be held in situations where the post-mortem or next of kin notification are pending. The officers knew that the post-mortem was pending and knew that next of kin had not been notified, in fact, the body had not even been formally identified when the scene was released.

Sergeant Whipple testified that at the time, it was common practice to release sudden death scenes prior to the post-mortem if there was nothing suspicious. There was no evidence to the contrary. To release the scene then, Staff Sergeant Harrison must have determined that the death was nonsuspicious. Furthermore, the body had not yet been identified, the post-mortem was pending, and the next of kin had not been notified, meaning, they had not been interviewed to ascertain if they may have possessed information to suggest foul play. I find this concerning.

Staff Sergeant Harrison testified he does/did not interfere with the role of the Forensic Identification Unit at a scene. In my experience, his role would not be to instruct members of the Forensic Identification Unit how to seize exhibits, rather what exhibits ought to be seized and/or the nature of the investigation so they could properly determine what items they felt

important enough to seize; anything short of this type of reporting relationship is irresponsible scene management.

At tab 61 of Exhibit #7 is the Ontario Provincial Police Criminal Investigation Branch review of the police investigation into the death of Stacey DeBungee. One of the areas they analyzed was scene management. The review criticized the lack of scene photographs which resulted in "difficulty in determining the positioning of the body and its overall state prior to the removal of the deceased from the water." It also resulted in difficulty in determining Stacey DeBungee's point of entry into the river.

Staff Sergeant Harrison as the officer in charge is ultimately responsible for every aspect of the investigation including scene management, but I find that he cannot be held accountable for the photographs that were or were not taken by the Forensic Identification Unit. He would be aware that they were photographing the scene, but he would have no way to know if they accurately and thoroughly captured the scene as comprehensively as would be expected. His responsibility is overall scene management, not to specifically supervise members of the Forensic Identification on how to seize and capture evidence.

Staff Sergeant Harrison testified that he believed Stacey DeBungee entered the river at the point where he was located. However, I fail to understand how he arrived at that conclusion. There was no evidence that the riverbank was canvassed or searched for evidence suggesting a different entry point, nor were the investigators in possession of evidence concluding the point of entry, it was an assumption. Ensuring a comprehensive search of the riverbank was conducted in an attempt to ascertain the point of entry was the responsibility of Staff Sergeant Harrison. It was irresponsible to assume that Stacey DeBungee's point of entry into the river was at the same location as he was found when there was no evidence to warrant such a conclusion.

The Ontario Provincial Police were critical of the fact that the scene was not video recorded. I agree that it could have assisted, and should have been done, but I find this is more of a training issue than a disciplinary matter. It was not stated in policy that sudden death scenes were to be video recorded.

The Ontario Provincial Police noted from the photographs that were taken, there were items present which were not seized and should have been. The report noted:

> Although several exhibits were identified and seized from the scene, a review of the photographs revealed that other items were also present at the scene which had not been seized and may have had evidentiary value. For instance, exhibit #6 is listed as a cigarette butt; however, there are several other cigarette butts visible in the scene photographs which do not appear to have been seized. One in particular looks to have been recently deposited and positioned in close proximity to David Sapay's health card.

It is unclear why some cigarette butts were determined to have evidentiary value and not others.

Detective Primmer testified that the cigarette butt in question should have been seized, she could not explain why it was not. Police officers make mistakes, a level of perfection is unattainable and is not the standard. Of concern, is that the overall approach at the scene from a management perspective, is consistent with the officers having already concluded that the death was nonsuspicious as opposed to investigating what, other than an accidental drowning, may have occurred.

The Ontario Provincial Police were critical of the fact measurements were not "taken with respect to the water depth where the body was located, the slope of the grassy riverbank or the proximity of exhibits to the body and any suspected entry point." I agree. The working theory was that Stacey DeBungee passed out and rolled into the river at the same location as he was found. Therefore, it would have been important to know the slope of the riverbank at that specific location to assess the likelihood of this actually occurring resulting from the steep angle of the slope. Water depth and temperature may not have been required as evidence to support their working theory, but it may have held evidentiary value if it was later deemed a homicide and the matter was to be criminally prosecuted.

Mr. Butt submitted that Staff Sergeant Harrison was actively engaged at the scene and was too busy to be held accountable for not supervising the Forensic Identification Unit. I disagree that he was too busy to take carriage of scene management, it was his responsibility. There was nothing in his notebook entries indicating that he was busy at the scene, in fact, there is very little reference to him doing anything at all at the scene other than observing.

The Notice of Hearing alleges that there was no forensic examination of exhibits, but there was no evidence indicating what evidence ought to have been submitted to the Centre of Forensic Sciences for expert examination. The evidence does not support neglect of duty as it relates to this particular assertion. Similarly, I do not find that not having the scene video recorded meets the standard of neglect of duty. While Staff Sergeant Harrison was responsible for scene management, failing to seize a cigarette butt, which should have been seized, can be considered an oversight. However, when taken into consideration in context with all the evidence, I find the poor scene management supports the assertion that Staff Sergeant Harrison decided that Stacey DeBungee was intoxicated (based on no evidence) rolled into the river and drowned. That assumption adversely affected how the scene was managed.

It is important to note that at that very moment, the Inquest into the Deaths of Seven First Nations was underway. Could there be greater motivation to ensure this investigation was thoroughly investigated which included appropriate scene management?

I find that the decision to release the scene at the time that it was, supports the neglect of duty allegation given the totality of the evidence. It was too soon to ascertain that the death was nonsuspicious, Stacey DeBungee had not been identified, his body had not been fully examined for injury, the post-mortem was scheduled but pending, next of kin had not been notified and critical interviews of his family members and Mr. Sapay remained outstanding.

Whether the Forensic Identification Unit and the coroner agreed with the decision to release the scene is irrelevant, the decision is the responsibility of the officer in charge, Staff Sergeant Harrison.

Prematurely concluding that the death was non-criminal when the evidence did not support the conclusion that foul play had been excluded.

Staff Sergeant Harrison's unsatisfactory crime scene management supports the assertion that Staff Sergeant Harrison prematurely concluded the death of Stacey DeBungee was non-criminal when the evidence was insufficient to support that theory. His assumption was so early into the investigation that it adversely affected scene management.

This allegation does not include a specific time period, it simply alleges that Staff Sergeant Harrison "prematurely" concluded the death was non-criminal. It is important then, to consider the evidence as it was known to Staff Sergeant Harrison at various stages of the investigation. Also, I find this particular allegation requires consideration of the overall actions of the investigative team under the supervision of Staff Sergeant Harrison. Consequently, in addition to the scene management analysis just conducted, I will consider the following allegations under this heading rather than assess them individually:

- Failure to formally interview persons who had been in the company of Stacey DeBungee shortly before his death.
- Failure to conduct formal follow up interviews with several witnesses.
- Failure to review reports in the investigative file on an ongoing basis.
- Approving media releases that indicated the death was "deemed non-criminal" and that "no foul play" was suspected, prior to having the evidence to support this conclusion.
- Not contacting a material witness in a timely manner and only contacting them a long time after the material event.

In *Moore*, the Commission noted:

> The fact that there were several officers present at the time does not relieve Constable Moore, as officer in charge, of the responsibility for ensuring that all of the appropriate investigative steps were taken after RM was arrested and the van seized…

Staff Sergeant Harrison is a very experienced police officer and investigator, having previously supervised numerous sudden death investigations and had been the officer in charge of

several successful homicide investigations. There was no suggestion that he was not qualified to properly supervise and conduct this sudden death investigation. As noted earlier, the Criminal Investigation Management Plan states that the detective in the Criminal Investigation Branch is responsible for ensuring each incident is investigated to its completion, to assemble all evidence, and present it in Court, if charges are laid. As the officer-in charge of the sudden death investigation, Staff Sergeant Harrison bore the responsibility of ensuring that the incident was properly and thoroughly investigated.

In the Ontario Provincial Police review of the Thunder Bay Police Service Stacey DeBungee death investigation, they concluded:

> The scene was released at 11:45 a.m., on October 19, 2015; however, the post-mortem was not conducted until October 21, 2015. Further, the lead investigator Detective Harrison wrote in his notes that at 10:45 a.m., he believed the death was non-suspicious in nature. This conclusion was reached before a cause of death had been identified and despite the fact that witness Mike Chartier had approached officers at the scene and stated that he had witnessed individuals fighting at the location the evening prior. Based upon Thunder Bay Police Service policy “investigations into sudden or unexplained deaths and found human remains be considered potential homicides and be undertaken in accordance with the police service's Criminal Investigation Management Plan” and coupled with the details contained within Detective Harrison’s notes, there does not appear to be any basis for his conclusion at that stage of the investigation.

I am not impacted by the findings in that report, but, independent from it, I have arrived at the same conclusion. I note however, that Detective Harrison was unaware of Mr. Chartier’s information at the time; it had been received by Constable Verescak, but not relayed to members of the Criminal Investigation Branch.

Nonetheless, at the moment that Staff Sergeant Harrison made a notebook entry indicating that the sudden death was nonsuspicious, he knew that Stacey DeBungee had previous contact with the Thunder Bay Police Service for *Liquor Licence Act* infractions. Simply put, so what. There was no evidence whatsoever at that time that Stacey DeBungee was intoxicated or even that he had been consuming alcohol previous evening. It goes beyond being irresponsible, it is the definition of neglecting his duties to merely assume that the deceased had been intoxicated. This presumption led to his working theory of Stacey DeBungee passing out from alcohol consumption, rolling into the river, and drowning. He testified that his mind was open to other theories, but none of them were ever documented and no witness presented in evidence, any other specific possibility that had been considered.

Staff Sergeant Harrison’s notebook entry specifically reads:

> No obvious signs of trauma/foul play.

That notebook entry does not necessarily mean there was no foul play, just that there was no obvious sign of foul play. However, just a few lines later in his notebook, while still at the scene, Staff Sergeant Harrison wrote that the scene would not be held because the death was not suspicious. At that time, he knew that David Sapay's identification was located in close proximity to the body of Stacey DeBungee. It was an unexplained development at the time.

At that moment, the body had not yet been identified and the family had not been interviewed. Staff Sergeant Harrison had no working knowledge about the background or family history of Stacey DeBungee before deciding the death was not suspicious in nature. It was a premature assumption. The family may have had information that Stacey DeBungee was depressed or that he was at odds with someone; any number of circumstances could have existed which may have caused the police to look at the situation differently.

It was not as if the death had been observed by a person and it could be explained as an accident or suicide for example; all that was known is that there were no obvious signs of trauma to the body. I emphasize the word obvious; a thorough examination could not occur until the post-mortem. At that time, the death should have been treated as unexplained. I agree that there was no evidence pointing to a homicide, but just as clearly, there was no evidence to support the conclusion that the death was nonsuspicious. Further investigation was required, but very little if any investigating actually occurred.

This brings me to the issue of not reading reports in a timely manner. I take no issue with Mr. Butt's submission that there was a systemic issue; the reporting structure was such that Constable Verescak's Sudden Death Report went to his direct supervisor for approval rather than to Staff Sergeant Harrison. But I do not accept that therefore, Staff Sergeant Harrison was not duty bound to read that report, or to cause it to be read by his lead investigator Sergeant McKever. This was a sudden death investigation, not an insignificant file such as a mischief or theft; it involved the death of a person, necessitating a corresponding, principled, and focused response by police. At the very least, that would include reviewing all reports submitted related to this incident.

Constable Verescak submitted the Sudden Death Report on October 19, 2015, at 1:28 p.m. wherein he noted:

> The male identified himself as Mike Chartier, and he wished to inform Constable Verescak that on October 18, 2015, he was riding his bike approximately one half hour before sunset when he came across four or five Native Canadians drinking in the area where officers had located the body. He stated that there was one female in the group, and two males were pushing each other around near the area of the fence on the west side of the bike path. He stated that all parties were highly intoxicated and made him feel uncomfortable…

Staff Sergeant Harrison testified that had he read this report, he would have directed Sergeant McKever to interview Mr. Chartier immediately. This was vital information, lost, due to a lack of communication at the scene, and because the Sudden Death Report was not reviewed by the investigating officers. The former could not necessarily be controlled by Staff Sergeant Harrison but reading the Sudden Death Report is basic yet essential police work. Again, I note that this is a sudden death investigation, nothing can be overlooked if one is truly keeping an open mind about the circumstances that led to the death.

According to his notes, Staff Sergeant Harrison arrived on scene at 9:39 a.m. He noted that the Forensic Identification Unit was present but did not make note of whom. He did not make note of Sergeant Whipple or Sergeant McKever being present, or what their roles were. There is no entry indicating that he assigned anyone to do anything. His notes indicate the coroner, Dr. Scott arrived at 10:45 a.m. The lack of detailed notes is consistent with the assertion that Staff Sergeant Harrison had already concluded that the investigation was resolved.

While on the scene, Dr. Scott, indicated that an autopsy would be conducted. Staff Sergeant noted that the deceased person was possibly Stacey DeBungee, a person who had "numerous liquor licence offences." He noted that there was "no obvious signs of trauma/foul play," and before the coroner had cleared the scene at 11:02 a.m., Staff Sergeant Harrison noted the death was deemed "not to be suspicious."

Staff Sergeant Harrison had been at the scene for just over one hour prior to the arrival of the coroner and had less than one page of notes that did not articulate what if any investigative measures had been undertaken. After the coroner was at the scene for less than 17 minutes, Staff Sergeant Harrison noted that death was not suspicious. Staff Sergeant Harrison testified that he kept an open mind as to what may have occurred, but there is no evidence to support that position. There was no evidence of alcohol consumption, and there was no explanation as to why identification in the name of David Sapay was found at the scene. Potential witnesses at the scene were known to police but they were not interviewed by members of the Criminal Investigation Branch. I see no reason why not. The Criminal Investigation Branch attended sudden death scenes because of their expertise in criminal investigations including interviewing techniques. It makes no sense to not take advantage of those skills; they should have been engaged with the potential witnesses at the scene. This observation could be considered applying hindsight to the investigation. I am not suggesting this particular omittance amounts to neglect of duty on its own, merely that it is consistent with assuming the death was nonsuspicious, thereby eliminating the need for the Criminal Investigation Branch to obtain formal statements.

During his interview with the OIPRD, Dr. Scott stated that it was not wise for the police to characterize the death as "non-criminal" without the benefit of an autopsy. Dr Scott also stated:

> …[Dr. and police] just started discussing what possibly happened. U'mm, Stacy was known to be an alcoholic or heavy drinker and they thought, well, that's, it's happened before, u'mm, but they were obviously going to go and look and try and find out what had happened, whether or not he just fell in, whether or not there was an altercation, they just talked about having to go and interview people and look around and find out what they thought might happen.

Dr. Scott clarified:

> U'hhh, we have had, they've found known alcoholics in the river in two or three feet of water, not in that same spot, but in other places, locations around Thunder Bay. And, u'hhh, it just seemed to be a popular drinking spot and you know, just along all of the banks of the river and they've had, u'mm, some drownings in very shallow water, mostly alcoholics with very high, u'mm, high alcohol levels in their blood at an autopsy.

I accept Dr. Scott's recollection of events, but I am more than troubled that he left the scene with the belief that Staff Sergeant Harrison was planning to conduct interviews, to investigate, and to determine how Stacey DeBungee ended up in the river, yet no such investigation occurred. Instead, all that did occur was that the body was identified by comparing tattoos on the body with those noted on Niche RMS and the Canadian Police Information Centre (CPIC) and the next of kin were notified. Not one formal interview was conducted.

Staff Sergeant Harrison found it noteworthy to record in his book that three persons came out of the wooded area, but that they offered no information. The Agreed Statement of Facts included the following:

> Constable Bernst encountered three individuals on the scene who identified themselves as Corrie Sainnawap, Samaria Etherton, and Adam Achnespineskum. It was later determined that Samaria Etherton is also known as Marie Spence.
>
> Mr. Achnespineskum told Constable Bernst that he was advised by Mr. Sandy that there was a person who had drowned in the river. The three individuals did not know who the person that had drowned was, however the three individuals found a health card by the riverbank.

I find it troubling that Staff Sergeant Harrison found it unnecessary to have these individuals interviewed by members of the Criminal Investigation Branch at the time to ascertain more information about the health card, where it was found, who found it, what observations, if any were made etcetera. This is basic police work and falls under the responsibility of the officer in charge, Staff Sergeant Harrison. I am not viewing this through the lens of hindsight because these individuals did actually possess what would have been information useful to the investigators; regardless, potential witnesses at the scene of an unexplained death must be formally interviewed. I fully expect that Staff Sergeant Harrison would have ensured this was

done if he had taken the view that the death was unexplained. The fact that he did not see to it is consistent with releasing the scene prior to the post-mortem and not reading reports; he had already concluded the death was nonsuspicious in nature as opposed to being unexplained.

There is not a notebook entry in Staff Sergeant Harrison's notebook about a media release, or that Chris Adams had attended the scene. Sergeant McKever noted that at 10:10 a.m., Mr. Adams was at the scene. At 12:34 p.m., Mr. Adams sent an email to Staff Sergeant Harrison confirming that he was disseminating the media release as they had discussed. Of concern, is that the release included that the "initial investigation does not indicate a suspicious death."

In relation to the initial media release, the Ontario Provincial Police noted in their review of the investigation into the death of Stacey DeBungee that:

> Due to the preliminary stage of the investigation at this point, it was too early to draw such a conclusion.

I agree but I do not find that in so doing, it amounts to a neglect of duty on its own. When considered in totality with all the evidence however, the media release is consistent with Staff Sergeant Harrison's working theory. The release insinuated that the investigation was ongoing but that preliminary results did not indicate that the death was suspicious. The release is consistent with Staff Sergeant Harrison's working theory, but more concerning, is that virtually no investigation had been conducted to draw such a conclusion. Even more disturbing, is that despite informing the coroner, and insinuating to the public via this media release that further investigation was warranted to determine the manner in which Stacey DeBungee died, no such investigation ensued.

At 2:35 p.m. Staff Sergeant Harrison learned that Stacey DeBungee was being reported as missing to the Thunder Bay Police Service. At that time, the body had not been identified as being Stacey DeBungee. I do not understand why at that time, there was not an attempt to have the body identified by the next of kin filing the report. In any event, the body was identified a short time later to the satisfaction of Staff Sergeant Harrison by comparing Stacey DeBungee's tattoos with those recorded in CPIC and Niche RMS. At Approximately 2:50 p.m., Staff Sergeant Harrison assigned Sergeant Whipple and Sergeant McKever to make the next of kin notification.

At 3:45 p.m., Staff Sergeant Harrison noted that the next of kin was Stacey DeBungee's common-law spouse, but she was not named. There is not a notebook entry about what had occurred during that notification and no further entries on that date. However, Staff Sergeant Harrison testified that Sergeant Whipple and Sergeant McKever returned to the office and informed him that Stacey DeBungee was last seen passed out near the river. He testified that

witness statements were not taken and were not required, that they could be taken in the future if needed.

I find not taking statements from people who may have last seen Stacey DeBungee alive, indicative of a person who had already concluded what had happened, and that therefore, no further investigative efforts were required. Staff Sergeant Harrison did not treat the incident as an unexplained death, he treated it as an accidental death resulting from alcohol consumption and subsequent drowning. It would have been proper to obtain statements from everyone likely to possess information about Stacey DeBungee and/or his death immediately, especially knowing then, that the post-mortem was not likely to occur until October 21 or 22 (as per Staff Sergeant Harrison's notebook entry at 2:39 p.m.). The need to obtain formal statements was required, especially knowing that one of the persons present was Cory Linklater, the brother of David Sapay, knowing that David Sapay's brother stated he last saw Stacey DeBungee and David Sapay passed out together the previous evening. This information was vital to the investigation and clearly warranted formal statement taking. Furthermore, Mr. Sapay remained unaccounted for at the time, and one of the persons at the next of kin meeting was not identified by name. Formal statement taking from these individuals was required to thoroughly investigate the matter and to ascertain the whereabouts of Mr. Sapay to facilitate a timely interview with him.

It was not until 2:30 p.m. on October 20, 2015, that Sergeant Whipple and Sergeant McKever attended the last known residence of David Sapay. The scene was cleared more than 24 hours earlier, but there was no discussion in evidence about why they did not look for Mr. Sapay sooner. Unable to locate him at the residence, they left a business card and requested that they be contacted if he was located by police. David Sapay was quite possibly, the last person to see Stacey DeBungee alive and was well positioned to provide information about how Stacey ended up in the river, and how/why his identification was found next to the body. Clearly, this was an important interview to obtain as soon as possible. Instead, the investigation ended on that date; nothing further was done beyond adding Mr. Sapay to BOLO and MOB. The investigators did not go back to those individuals from the next of kin meeting, which included Mr. Sapay's brother, in an attempt to locate Mr. Sapay and took no other steps to locate him.

The second media release was circulated on October 20, 2015, at 10:15 a.m. It read as follows:

> The Thunder Bay Police are releasing the name of the person found deceased in the McIntyre River yesterday morning. The deceased is 41 year old Stacey Lance DeBungie [sic] of Thunder Bay. Mr. DeBungie's death has been deemed as non-criminal.

The Ontario Provincial Police noted in their review of the investigation into the death of Stacey DeBungee that:

> It [the media release] identified Stacy DeBungee and stated that "Mr. DeBungee's death has been deemed non-criminal." There is no indication that investigators had obtained or garnered any new information which would alter the status of the investigation in the time frame between the first and second media release. At this point in the investigation the post-mortem examination had yet to be conducted and the cause of death had not been established. Therefore, at that point there was no basis to determine that the death was non-criminal in nature.

Mr. Butt agreed that the second media release was problematic, it determined the death was non-criminal in nature. I agree that it is confirmatory in nature and that nothing had changed since the initial media release from an investigative perspective to allow for this determination.

At issue, is who approved this release. The Thunder Bay Police Service Media Relations Policy, Part 2 Chapter 12 states:

> In all cases where information is released regarding an ongoing investigation of a serious criminal matter, the releasing officer shall contact the investigators assigned to the case to ensure the information does not and will not jeopardize the investigation…

Mr. Adams testified that he would not have released the second media release without approval, but he could not be certain who approved the release, it could have been Staff Sergeant Harrison, Staff Sergeant Kaucharik or Inspector Levesque. Staff Sergeant Kaucharik testified she did not see the draft of the second media release, nor did she recall approving it.

In answer to a question about the second media release in his in his interview with the OIPRD, Staff Sergeant Harrison stated:

> I probably did but I don't recall that one 'cause, he probably did send it to me for approval…
>
> I honestly can't say whether he, like he should have [sent an email for approval]. But I can't I recall the first one. I do recall the first one… The second one I don't recall.

Mr. Dubois and Ms. James submitted that there was sufficient evidence to warrant drawing an inference that Staff Sergeant Harrison authorized the second media release. I agree that the second media release was consistent with Staff Sergeant's working theory at the time, and while it is likely, the evidence is not sufficient to conclude that Staff Sergeant Harrison must have been the person who approved the second media release. Staff Sergeant Kaucharik testified that she did not approve the media release, but she also noted that she informed Mr. Adams that the name of the deceased could be released to the public. It is feasible that the release was approved in theory during that discussion.

There is not a notebook entry in Staff Sergeant Harrison's notebook related to this investigation on October 20, 2015, but he testified that he was updated about David Sapay not being located. On October 21, 2015, Staff Sergeant Harrison noted that he met with Brad DeBungee and later noted the results of the post-mortem, that there was no anatomical cause of death, no signs of injury, no foul play, likely drowning pending toxicology report. There appears to have been nothing further done in the investigation, no attempts to locate Mr. Sapay, and it was determined no formal interviews of any person were required.

Of note, Staff Sergeant Harrison entered a plea of guilty for neglect of duty related to his failure to speak with private investigator Mr. Perry. I accepted that guilty plea based on the Agreed Statement of Facts wherein he admitted to the act, and acknowledged that in so doing, it amounted to the offence of neglect of duty.

Staff Sergeant Harrison had a duty to speak with Mr. Perry, a person who may have possessed information he wanted to share with police about his investigation into the sudden death of Stacey DeBungee. Staff Sergeant Harrison wilfully chose not to do so. There was no lawful excuse for not speaking with Mr. Perry. By entering his guilty plea, Staff Sergeant Harrison conceded his decision was serious enough to cross the line from a performance consideration to that of misconduct.

The same analogy can be drawn from his failing to ensure that potential witnesses were interviewed. Staff Sergeant Harrison had a duty as the officer in charge to ensure that those individuals identified at the scene and those identified at the next of kin notification meeting, all of whom had the potential to provide significant information to advance the investigation, were formally interviewed. In my opinion, failing to ensure these potential witnesses were formally interviewed is more serious than ignoring the request to meet with a private investigator; these individuals had direct and personal knowledge to provide investigators and the investigators had easy access to them yet, Staff Sergeant Harrison wilfully decided against it.

I have not used hindsight or armchair quarterbacking in this analysis, my observations about the sudden death investigative failings are from the perspective of basic, duty-bound responsibilities, expectations of any criminal investigator in the province of Ontario. For example, the Agreed Statement of Facts noted that

> At approximately 2:14 p.m., resource officer Constable Janine Lewkoski received a telephone call from Cornelius Wapoose, the nephew of Stacey DeBungee's common law spouse Evelyn Kwandibens, to report that Stacey DeBungee was missing. He, and his sister Ethel Wapoose, indicated that Stacey DeBungee had been in the company of Ethel Wapoose, David Sapay, John Alex Waswa and Corey Linklater the previous night…

> At approximately 3:15 p.m., Sergeant Whipple and Sergeant McKever attended at the residence of Evelyn Kwandibens [for the next of kin notification]. Present at the home was also Ethel Wapoose, Cornelius Wapoose, Corey Linklater, and John Alex Waswa…
>
> Ethel Wapoose advised that she had been drinking with Stacey DeBungee as well as with David Sapay, John Alex Waswa, Corey Linklater, Cornelius Wapoose, the previous night. When they left the riverbank, Stacey DeBungee and David Sapay were passed out on the bank.

This is clearly information that should have caused Staff Sergeant Harrison to recognize the need to obtain formal statements. These are the people who were with Stacey DeBungee just before he died. They should have been questioned and asked to provide information such as but not limited to, the supposed altercation that had occurred that evening and the relationship between Stacey DeBungee and David Sapay. Instead, Staff Sergeant Harrison did not even make a notebook entry about the meeting or who was last seen with Stacey DeBungee.

The same can be said about not obtaining formal statements from witnesses at the scene. The following notation from the Agreed Statement of Facts clearly includes information about witnesses finding identification which necessitated further investigation:

> Mr. Achnespineskum told Constable Bernst that he was advised by Mr. Sandy that there was a person who had drowned in the river. The three individuals did not know who the person that had drowned was, however the three individuals found a health card by the riverbank.

Mr. Butt submitted Staff Sergeant Harrison did not come to a premature conclusion, he merely followed the evidence to conclude the death was not suspicious. While there is truth in that statement in the sense that the evidence did not indicate the death was as a result of a homicide, the investigation was so inadequate, no other alternative was available; if you don't investigate, how can you obtain information about a homicide or potential homicide?

The following observation found in the Broken Trust report in relation to an unconnected matter is analogous to this matter:

> There are obvious challenges associated with obtaining reliable information from witnesses whose perceptions may have been affected by alcohol at the relevant time. Evidence that M.N. was impaired by alcohol when he was last observed also must be considered in determining the events that led to his death. However, these challenges make the need for a thorough and effective investigation all the more important, rather than less important…

It was incumbent upon Staff Sergeant Harrison to ensure formal statements were received as soon as possible from those persons who were well positioned to offer assistance to the investigation, people who may have to helped determine how Stacey DeBungee came to be in the river. Instead, he deemed it not necessary because he had prematurely deemed the death nonsuspicious.

Staff Sergeant Harrison testified that when he conversed with Brad DeBungee on October 20, 2015, he informed him that his brother's death was still under investigation, that he did not believe it was suspicious, and he was awaiting the post-mortem results. The problem with the statement is that the matter really was not still under investigation; no further investigative steps actually ensued. Staff Sergeant Harrison recognized the need to interview David Sapay, his identification was at the scene, and he was theoretically, alone with Stacey DeBungee at the time of the sudden death. Yet, the attempt to locate him was feeble; officers attended his residence on one occasion, the day following the sudden death rather than immediately, and placed him on BOLO and MOB but they never followed up beyond this. Mr. Sapay was not interviewed for five months; greater effort was needed to locate and interview Mr. Sapay as soon as possible to ascertain what had happened at the riverbank. The failure to do so is yet another illustration of the mindset that Stacey DeBungee was intoxicated, passed out, rolled into the river, and drowned. If there was any question in the minds of the investigators about what had occurred, this interview would have been prioritized.

In summary, I find it was reasonable for Staff Sergeant Harrison to not utilize the Major Case Management system, and acceptable that he did not direct the Forensic Identification Unit to submit exhibits to the Centre of Forensic Sciences Centre. I find the evidence does not clearly show that Staff Sergeant Harrison authorized the second media release.

I accept that the evidence collected did not suggest foul play, but the investigation was so inadequate, it did not allow for the collection of evidence which might give rise to suspicion as to the manner of death. It was difficult for the investigating officers to have uncovered evidence of a potential homicide when the matter was not properly or thoroughly investigated.

The totality of the evidence, including failing to formally interview witnesses, failing to review reports and prematurely concluding that the sudden death of Stacey DeBungee was non-criminal when the evidence did not support the conclusion that foul play had been excluded, amounts to neglect of duty; Staff Sergeant Harrison failed to investigate the sudden death of Stacey DeBungee with the mindset that it could have been a potential homicide.

As noted by Mr. Perry in his investigative report, the cause of death could have been attributed to accidental, misadventure, suicide, or due to a criminal act. According to the evidence, Staff Sergeant Harrison never considered any other option other than accidental.

This investigation was not merely sloppy or substandard. Staff Sergeant Harrison's decisions were not the result of a lack of training or inexperience, he was well suited to conduct a sudden death and/or homicide investigation and understand his requisite duties. The actions, and inaction of Staff Sergeant Harrison rise beyond that of a performance issue. As the officer in charge, he was duty bound to ensure that a thorough, open-minded, sudden death investigation resulted. Instead, he wilfully neglected to ensure duties were completed. Based on speculation, void of evidentiary foundation, Staff Sergeant Harrison presumed the sudden death of Stacey DeBungee was accidental and consequently, failed to treat the incident as a potential homicide.

Discreditable Conduct

Mr. Butt questioned why Staff Sergeant Harrison or Sergeant Whipple would act discriminatory in relation to this investigation, when there had never been a similar concern about this type of behaviour in the past. Deputy Hay agreed that as an executive who has wrestled with these issues for years, he understood the distinction between systemic and overt racism by individuals. Deputy Hay indicated he had no contact with Staff Sergeant Harrison or Sergeant Whipple during the investigation but in the broader sense, he knew them to be exemplary officers. He had confidence in their ability as investigators and had never seen them partake in jokes or take part in racist behaviour.

There is no evidence suggesting Staff Sergeant Harrison or Sergeant Whipple held overt biases about Indigenous people that adversely affected any aspect of any other investigation. As noted, because other officers of the Thunder Bay Police Service may be considered racist, does not suggest then, that all officers of the Thunder Bay Police Service are racist. Likewise, because Staff Sergeant Harrison and Sergeant Whipple did not demonstrate visible racism historically, and because their investigations may not have been influenced by unconscious biases in the past, does not mean that it could never happen, and that it did not happen here. The evidence must be examined specific to this matter, and a determination made as to whether Staff Sergeant Harrison or Sergeant Whipple failed to treat or protect persons, in particular Stacey DeBungee and his family, equally and without discrimination, with respect to police services because of the family's Indigenous status.

Earlier, I noted that it is theoretically possible for Sergeant Whipple to have been found not guilty of neglect of duty, yet still be found guilty of discreditable conduct for failing to treat or protect persons equally, without discrimination with respect to police services because of their Indigenous status. In my mind, to make such a finding, the evidence must show that Sergeant Whipple played an active role in the decisions that directly affected this investigation.

There is no evidence indicating Sergeant Whipple participated in any decisions made at the scene. Similarly, there is no evidence that he was responsible for any decision making during

the course of this investigation, his role was that of a support person. I find the evidence insufficient to support the assertion that Sergeant Whipple committed the act of discreditable conduct considering his limited role in the Stacey DeBungee sudden death investigation.

Turning to the facts respecting Staff Sergeant Harrison. This is an important case and it covers a novel area of law, but the issue to be considered is not particularly complicated. Simply put, did Staff Sergeant Harrison fail to treat or protect persons, specifically Stacey DeBungee and his family, equally and without discrimination with respect to police services because of their Indigenous status? I determined that Staff Sergeant Harrison was neglectful in his duties related to his investigation into the sudden death of Stacey DeBungee. Essentially, the issue now, is why did that occur?

Mr. Butt submitted I ought to take the same approach that the hearing officer took in *Gauthier* and not rely on the Broken Trust Report or the Senator Sinclair report. In *Gauthier*, the hearing officer decided against reading or considering a report on how the Toronto Police Service handled missing person complaints. Sergeant Gauthier was charged with neglect of duty and insubordination for failing to abide by internal policy as it pertained to statement taking and evidence gathering. The hearing officer determined that Justice Epstein's report was systemic in nature, while the hearing focussed on whether internal policy was breached during one particular incident. The hearing officer decided the report would not be assistive in his decision-making process.

The Broken Trust report originated as a direct result of the complaints lodged by Brad DeBungee and James Leonard. The Broken Trust report is so related to these allegations, that parts of the report needed to be redacted because it contained information too specific and detailed, including findings encroaching on my role as the hearing officer; clearly, the subject matter is relevant to this proceeding.

There is a significant difference between the Epstein report in *Gauthier* and the Broken Trust report. They were both looking at systemic issues, but the Broken Trust report was tasked to investigate, and respond to concerns raised by Indigenous leaders and community members that the Thunder Bay Police Service investigations of Indigenous deaths and other interactions, devalued Indigenous lives, reflected differential treatment, and were based on racist attitudes and stereotypical preconceptions about Indigenous people. It is virtually on point with regard to the discreditable conduct allegations. Consequently, I find the report to be very relevant to this proceeding. However, I am very aware that because the report identified that systemic racism existed in the Thunder Bay Police Service, that does not suggest that all officers are racist, or that therefore, Staff Sergeant Harrison's neglectful conduct must have been as a result of discrimination. The Broken Trust report and the Sinclair report are meant to provide context, to assist the tribunal in understanding systemic racism and how it affected the Thunder Bay Police Service in general, at the time of the alleged incidents.

Mr. Butt submitted that the OIPRD's lead counsel during his interview with Staff Sergeant Harrison in relation to this alleged misconduct, promised that the OIPRD's systemic review (ultimately, the Broken Trust report) would be kept separate from the internal complaint process. I have reviewed the transcript of that interview and find that the interviewer was clear that the interview questions would not be related to the systemic review. I do not accept that the interviewer in so doing, promised that the systemic review could not be used during this hearing process.

I accept Mr. Butt's submissions about the differences between a systemic review and a disciplinary process including a different standard of proof. As noted, Mr. Butt agreed the report was properly before the tribunal, noting that it contains conclusions pertaining to the systemic review of the Thunder Bay Police Service. Mr. Butt submitted the Broken Trust report can be properly used to drive conclusions in the sense that it can be persuasive but submitted I must be cautious not to confuse a systemic review based on a lower standard of proof with what is to be considered misconduct.

I accepted the Broken Trust report and the Sinclair report as exhibits, but not on the truth of their content, in part, due to the standard of proof utilized in those reports; they contain opinions and findings but not to the standard of clear and convincing evidence. I note that the reports are very detailed and were based on lengthy investigations. I find that both reports are very relevant to this analysis, it is important to understand the general landscape that existed between the Thunder Bay Police Service and the community it policed.

I note that both reports were released in 2018 and this alleged misconduct occurred in 2015 and 2016. The Broken Trust report commenced on November 3, 2016, and in part, reviewed investigations dating back to 2009. The Sinclair report was undertaken between July 21, 2017, and October 31, 2018. I am satisfied that the material they considered included the time frame related to these allegations.

The Broken Trust report is 206 pages in length. I have included the following snippets from the report as I find them noteworthy and assistive to my analysis. In part, the report stated:

> In March 2016, the OIPRD received two complaints about the conduct of officers who were assigned to investigate the 2015 death of an Indigenous man, Stacy [sic] DeBungee. In addition to these conduct complaints, the complainants, from Rainy River First Nations said there is a "crisis of confidence" in the Thunder Bay Police Service among members of First Nation communities. Accordingly, they requested the OIPRD conduct a systemic review to examine the underlying causes, and determine whether the Thunder Bay Police Service's investigative practices complied with the service's legal and policy frameworks and whether those could be improved. The Chief and Council of Rainy River First Nations were instrumental in pushing for this systemic review… I initiated this systemic review to investigate and respond to concerns about

> the way the Thunder Bay Police Service investigates the deaths and disappearances of Indigenous people.

The investigative team examined Thunder Bay Police Service investigations involving sudden deaths going back to 2009, including cases that were selected randomly or based on specific criteria. The primary focus was on the investigations of Indigenous deaths. The review also examined cases that were the subject of the Coroner's Inquest into the Deaths of Seven First Nations Youths and cases within the mandate of the National Inquiry into Missing and Murdered Indigenous Women and Girls. The investigators interviewed 36 current and former Thunder Bay Police Service officers and civilians on issues related to the systemic review. Investigators spoke with the Chief Coroner for Ontario, the Chief Forensic Pathologist, Nishnawbe-Aski Police Service, Anishinabek Police Service, York Regional Police investigators, Crown counsel in Thunder Bay, as well as other participants in the criminal justice system.

The investigators reviewed case files, Thunder Bay Police Service policies and procedures for missing persons and death investigations, along with details of training provided to officers related to investigations. Under the heading of "Key Findings and Recommendations," the report states:

> The inadequacy of Thunder Bay Police Service sudden death investigations the OIPRD reviewed was so problematic that at least nine of these cases should be reinvestigated. Based on the lack of quality of the initial investigations, I cannot be confident that they have been accurately concluded or categorized. A number of the Thunder Bay Police Service investigators involved in these investigations lacked the expertise and experience to conduct sudden death or homicide investigations. Investigators frequently misunderstood when matters should be investigated under the Major Case Management system, and failed to connect the autopsy report to their own investigations, failed to even find out the autopsy results or failed to understand the significance or lack of significance of the autopsy findings. On a number of occasions, attending forensic identification officers did not fulfill basic requirements. Investigators failed to know what was in their own investigative file, including supplementary occurrence reports filed by uniform patrol officers. Inadequate supervision resulted in many shortcomings identified in the investigative files we reviewed.
>
> My review identified the level of staffing in the Criminal Investigation Branch's General Investigation Unit as a major issue that must be urgently addressed. I found it unacceptable that a police service such as the Thunder Bay Police Service investigating a large number of serious, complex cases has no Major Crime Unit and investigators may lead the investigation of such cases without appropriate training or experience… I found serious issues with the relationship between the police and the coroners, including lack of coordination, delegation and information sharing…

> Our detailed review of cases involving sudden deaths of Indigenous men and women found the Thunder Bay Police Service investigators failed on an unacceptably high number of occasions to treat or protect the deceased and his or her family equally and without discrimination because the deceased was Indigenous. The Thunder Bay Police Service and its officers have attempted to explain the deficiencies in the investigations by referencing their workload as well as a lack of training and resources. In my view, these explanations cannot fully account for the failings we observed, given their nature and severity. The failure to conduct adequate investigations and the premature conclusions drawn in these cases is, at least in part, attributable to racist attitudes and racial stereotyping. Racial stereotyping involves transforming individual experiences into generalized assumptions about an identifiable group defined by race. We observed this process of generalization based on race in a number of the investigations we reviewed. Officers repeatedly relied on generalized notions about how Indigenous people likely came to their deaths and acted, or refrained from acting, based on those biases. My finding that investigations were affected by racial discrimination does not represent a determination that all Thunder Bay Police Service officers engaged in intentional racism. However, overall I find systemic racism exists in the Thunder Bay Police Service at an institutional level.

Under the heading of "challenges in Policing and Community, the report noted that the Thunder Bay Service submitted that many Indigenous people have a distrust of the police rooted in the historical context of broken treaties, the residential school experience and the "Sixties Scoop." The report cited the following quote from an unnamed member of the Thunder Bay Police Service:

> As a result, the police, in modern times, are not starting off on neutral ground with the Indigenous community. Instead the police are burdened with a legacy of social conflict with Indigenous people. This conflict is most apparent in communities with a significant Indigenous population, such as Thunder Bay … The geography, not the police practices of Thunder Bay lends itself to being the epicentre of police-Indigenous relations.

Chapter 9 of the report is titled Findings and Recommendations Regarding Racism. In part, it states:

> As detailed earlier, we conducted over 80 engagement sessions with community and Indigenous organizations, service providers and the general public. We also met with Indigenous leadership, including leaders from Fort William First Nation, Nishnawbe Aski Nation, Grand Council Treaty 3 and Rainy River First Nations. We heard a broad diversity of views expressed and also stories of lived experiences regarding discriminatory interactions with Thunder Bay Police Service officers.
>
> During my review we also interviewed 36 Thunder Bay Police Service officers, executive and civilian members and the Thunder Bay Police Services Board. I also

received submissions from the Thunder Bay Police Service as detailed in Chapter 7. We heard officers who attributed much of the division between the Thunder Bay Police Service and Indigenous communities to the media and social media broadcasting negative stories without also highlighting the positive interactions between the Thunder Bay Police Service and Indigenous communities.

The views and experiences described by community members and organizations along with Thunder Bay Police Service officers and the Thunder Bay Police Services Board contributed to my findings on racism, as well as the perception of racism, within the Thunder Bay Police Service. Of course, on these important issues, I considered all of the information collected during this review.

When I began this process, I was deeply concerned about the perception amongst Indigenous communities that these investigations, and other interactions with the Thunder Bay Police Service, reflected differential treatment based on systemic biases, racist attitudes and stereotypical preconceptions about Indigenous people.

Unfortunately, what I heard during our engagement sessions only heightened my concerns. Based on what was shared with me, it is clear that there is a crisis of confidence afflicting the relationship between Indigenous people and the Thunder Bay Police Service. There is a widespread perception that the Thunder Bay Police Service officers engage in discriminatory conduct, be it conscious or unconscious, ranging from serious assaults and racial profiling, to insensitive or unprofessional behaviour. Significantly, this perception was shared widely among members of Indigenous communities. It also found support elsewhere, including among non-Indigenous people, especially service providers, and some former and current senior police officers.

The police need the support of the community to do their jobs well. Because of this, it is essential that the police fulfil their duties in a manner that maintains public confidence. This is particularly the case when it comes to perceptions of racial discrimination. The police must not only do their jobs in a non-discriminatory manner, but the public must have confidence that this is the case. By that measure, the Thunder Bay Police Service to date, has not been successful in earning the confidence of Indigenous communities.

Moving from the perception of racism to racism itself, I now address issues surrounding racism within the Thunder Bay Police Service generally. It was central to this review to examine whether sudden death investigations involving Indigenous people are conducted in discriminatory ways.

It is important to develop a common terminology when discussing issues of racism and to distinguish between attitudes and actions. The terminology developed here is drawn from the Ontario Human Rights Code and related jurisprudence.

> Racism or racial prejudice is a belief, sometimes unconsciously held, about the superiority of one racial group over another. It can be expressed at an individual interpersonal level, or systemically at an institutional level. It is often manifested in stereotypes, in which people use racial categories to receive and understand information about others. Racial discrimination occurs when racial prejudice is a factor in how a person or institution acts. It often manifests in subtle and covert ways. Systemic discrimination occurs when an institution's culture, structure or practices create or perpetuate disadvantage for persons or groups.

Whether racist attitudes or stereotypes affect a person's actions is notoriously difficult to determine. This is because of the subtle and unstated ways in which racism can affect our behaviour. An extensive literature now attests to a range of micro-aggressions that may engender mental and physical health impacts upon Indigenous and racialized persons at the receiving end. The courts have recognized the insidious nature of racial stereotypes:

> "[b]uried deep in the human psyche, these preconceptions cannot be easily and effectively identified and set aside, even if one wishes to do so… Racial prejudice and its effects are as invasive and elusive as they are corrosive."

I am also mindful of the reality of systemic racism against Indigenous people in Canada, including "stereotypes that relate to credibility, worthiness and criminal propensity." This was stated in no uncertain terms over 20 years ago by the highest court in Canada, in language it adopted from the report, Locking up Natives in Canada: A Report of the Committee of the Canadian Bar Association on Imprisonment and Release:

> "Put at its baldest, there is an equation of being drunk, Indian and in prison. Like many stereotypes, this one has a dark underside. It reflects a view of native people as uncivilized and without a coherent social or moral order. The stereotype prevents us from seeing native people as equals."

The Ontario Human Rights Tribunal recently acknowledged the enduring power of these harmful stereotypes to influence police decision-making.

I have applied the following guiding principles in analyzing and determining whether there is racial discrimination against Indigenous people in death investigations based on our case reviews.

The courts have acknowledged that in this day and age, blatant forms of inter-personal discrimination are rather exceptional, and that subjective intent to treat someone

unequally is not required to prove racial discrimination. Rather than searching for direct evidence of overtly racist statements or actions, we must consider whether there is circumstantial evidence of racial discrimination. The Ontario Court of Appeal discussed the nature of this inquiry in a 2012 case involving an allegation of racial profiling by police:

> "Subjective intention to discriminate is not a necessary component of the test. There is seldom direct evidence of a subjective intention to discriminate, because '[r]acial stereotyping will usually be the result of subtle unconscious beliefs, biases and prejudices' and racial discrimination 'often operates on an unconscious level.' For this reason, discrimination is often 'proven by circumstantial evidence and inference'."

Under the Ontario Human Rights Code, a tribunal hearing a complaint of racial discrimination first considers whether there is a "prima facia case" of discrimination. Three elements must be satisfied for a prima facia case to be established:

1. The complainant is a member of a group protected by the Code.
2. The complainant was subjected to adverse treatment.
3. The complainant's gender, race, colour or ancestry was a factor in the alleged adverse treatment.

Once a prima facia case is established, the onus shifts to the respondent to provide a "rational explanation" for the conduct that is not discriminatory. This framework has been applied to investigations involving Indigenous people.

My finding that investigations were affected by racial discrimination does not represent a determination that all Thunder Bay Police Service officers engaged in intentional racism. In my view, officers may well have been influenced by racial stereotypes or unconscious bias. Whether or not this is the case, or whether officers consciously or unconsciously acted upon racial stereotypes, the fact remains that investigations were too often handled differently because the deceased was Indigenous.

Overall, I find systemic racism exists in the Thunder Bay Police Service at an institutional level. The Ontario Anti-Racism Directorate describes systemic racism as occurring when an institution maintains racial inequity or provides inequitable outcomes. It is often caused by hidden institutional biases in policies, practices and processes that privilege or disadvantage people based on race. This can be unintentional, and doesn't necessarily mean that people within an organization are racist. It can be the result of doing things the way they've always been done, without considering how they impact particular groups differently.

Senator M. Sinclair drafted the "Thunder Bay Police Service Investigation Final Report" dated November 1, 2018. It is a 139-page report, and under the heading of executive summary, the report states:

> This document is the report of an investigation undertaken between July 21, 2017, and October 31, 2018 by the Honourable Senator Murray Sinclair regarding the Thunder Bay Police Services Board. The Investigation was conducted in response to concerns raised by First Nations leaders from Nishnawbe Aski Nation, Grand Council Treaty 3 and the Rainy River First Nations regarding the Thunder Bay Police Services Board's ("Board") oversight of police services following a series of deaths and race-based violence against Indigenous peoples in Thunder Bay ("Investigation").

Under the heading of "The Findings," the report states:

> The Indigenous population of Thunder Bay experiences racism, both overt and systemic, on a daily basis. High-profile cases of murder and violence are only the tip of the iceberg; every Indigenous interviewee had a personal story, ranging from inferior service, verbal insults, and racial profiling to physical assaults, threats of violence, and, in many cases, the death by violence of friends or family members. This general climate of racism was most powerfully described by those who experience it daily; it was also reflected in an analysis of media coverage, statistics on rates of violent and race-based crime and prior studies on these issues.
>
> As a result, the Indigenous community has lost its confidence in the ability and, in many cases, the commitment of the Thunder Bay Police Service to protect them. Interviews and past inquiries reflect a relationship between the Indigenous community and police characterized by suspicion and distrust. Several factors have contributed to this.
>
> - A perception that police will minimize, dismiss, or fail to investigate complaints of violence against Indigenous people with diligence, particularly if intoxicants are involved;
> - Poor communication with Indigenous victims of crime and their families by the Thunder Bay Police Service;
> - A fear that formal complaints by Indigenous individuals directed to the Thunder Bay Police Service will result in repercussions against the complainant; and
> - A general failure by the Thunder Bay Police Service to address recurring categories of crime against Indigenous people in a comprehensive and systemic way.
>
> Negative perceptions of the Thunder Bay Police Service by the Indigenous community have been exacerbated over the years by incidents in which unmistakable racism is displayed by individuals within the Thunder Bay Police Service. These have ranged from well-documented public mockery and the dissemination of racist stereotypes, to

> use of excessive force against and humiliation of Indigenous individuals, to disturbing deaths in custody.
>
> Apart from its contribution to the climate of fear and suspicion, a further consequence of this distrust is a strong reluctance on the part of Indigenous victims or witnesses to report crimes, or to avail themselves of the police protection that non-Indigenous people take for granted.
>
> In a community with a high level of violence directed against a specific segment of the population, it is reasonable to expect that special efforts would be made to ensure the safety and security of that population, and to put resources, plans and policies in place to protect them. Several such initiatives have been taken in the past, and some provided evidence of a measure of success. However, the climate of mistrust persists. This suggests that the failure of the Thunder Bay Police Service to adequately protect the Indigenous community goes beyond actions and attitudes displayed by a few racist "bad apples" on the Thunder Bay Police Service; it is the manifestation of a deeper and more systemic problem…

Under the heading of, "The Key Issue," the report states:

> The issues identified with Thunder Bay policing through this Investigation are not the result of behaviours by individual racists, which could be addressed through disciplinary, staffing and training measures. Nor do they arise from the absence of planning and policy development by the Board, which would simply require that policy gaps be filled. They are indicative of a broader, deeper and more systemic level of discrimination in which an unacceptable status quo is viewed as the normal state of affairs, maintained and perpetuated by the structure and operations of organizations and agencies mandated to oversee them. Despite the goodwill and best intentions of individual members of the Thunder Bay Police Service and of the Board, dealing with the symptoms of systemic racism will do little to address the fundamental challenge.
>
> The Board has failed to recognize and address the clear and indisputable pattern of violence and systemic racism against Indigenous people in Thunder Bay. Moreover, the Board's failure to act on these issues in the face of overwhelming documentary and media exposure is indicative of willful blindness.

For the purpose of this tribunal, I note that this report, although it focused on the Thunder Bay Police Services Board and not the Thunder Bay Police Service, identified that systemic racism existed in the Thunder Bay Police Service. Similarly, the Broken Trust report came to the same conclusion. I also note that former Deputy Chief Hay acknowledged in his testimony that the Thunder Bay Police Service recognized that systemic racism existed within the Service.

How does the acknowledged existence of systemic racism in the Thunder Bay Police Service affect this decision? I am simply mindful of the extent to which systemic racism infiltrated the Thunder Bay Police Service; it affected, in some instances, how some officers conducted some investigations. That does not mean that therefore, systemic racism affected this particular matter, but it is worthy of consideration.

The Broken Trust report stated:

> Our detailed review of cases involving sudden deaths of Indigenous men and women found Thunder Bay Police Service investigators failed on an unacceptably high number of occasions to treat or protect the deceased and his or her family equally and without discrimination because the deceased was Indigenous.
>
> Thunder Bay Police Service and its officers have attempted to explain the deficiencies in the investigations by referencing their workload as well as a lack of training and resources. In my view, these explanations cannot fully account for the failings we observed, given their nature and severity.
>
> The failure to conduct adequate investigations and the premature conclusions drawn in these cases is, at least in part, attributable to racist attitudes and racial stereotyping. Racial stereotyping involves transforming individual experiences into generalized assumptions about an identifiable group defined by race. We observed this process of generalization based on race in a number of the investigations we reviewed.
>
> Officers repeatedly relied on generalized notions about how Indigenous people likely came to their deaths and acted, or refrained from acting, based on those biases.
>
> My finding that investigations were affected by racial discrimination does not represent a determination that all Thunder Bay Police Service officers engaged in intentional racism. However, overall I find systemic racism exists in the Thunder Bay Police Service at an institutional level.

I cannot rely on this particular quote, or the findings of the two reports to definitively conclude that Staff Sergeant Harrison's actions were affected by systemic racism, but the report findings can make up part of my overall considerations of the evidence. I realize that to make a finding of guilty, the evidence must be clear and convincing.

Staff Sergeant Harrison testified that other than failing to meet with Mr. Perry, his investigation was conducted satisfactorily. I came to a different conclusion. Staff Sergeant Harrison stated that the Thunder Bay Police Service received calls for service on a weekly basis in relation to people needing assistance in the river, some needed rescuing, some escaped on their own, while some others drowned.

Dr. Scott noted in his OIPRD interview that the Thunder Bay Police Service investigated similar deaths where “they’ve found known alcoholics in the river… it just seemed to be a popular drinking spot… they’ve had, some drownings in very shallow water, mostly alcoholics with very high alcohol levels in their blood at an autopsy.” Staff Sergeant Harrison testified there had been similar incidents investigated in the past where an intoxicated person passed out, rolled into the river, and drowned. He testified it was probable that those persons involved in the previously mentioned incidents were Indigenous.

The inference to be drawn from this evidence, is that the investigators concluded that because people had consumed alcohol to such an extent that they passed out, rolled into the river and drowned in the past, that that is what had occurred in this instance. But that is speculative, based on no evidentiary foundation whatsoever. The circumstances are similar, a male was found in the river. The fact that he was Indigenous, like the other individuals described in the previous incidents, is a factor that must have been persuasive in Staff Sergeant Harrison arriving at his working theory. Indigenous males in the previous incidents had drowned and had been deemed to have been intoxicated. I do not believe Stacey DeBungee’s Indigenous status was the only influencing factor, but I am convinced that in combination with the previous known similar incidents, and Stacey DeBungee’s previous *Liquor Licence Act* infractions, it contributed to his premature conclusions. I note that the evidence did not suggest that Stacey DeBungee was regularly investigated for multiple liquor offences, only that it had occurred in the past in Thunder Bay.

It is noteworthy that in Human Rights tribunals, it is permissible to rely on unconscious bias to make a guilty finding, but this is an employer/employee disciplinary tribunal. Not only is there a higher conduct standard in matters of police discipline cases, but I find that an officer should only be held accountable for misconduct that is ostensibly evident to them. In this matter, the evidence falls short of demonstrating that Staff Sergeant Harrison exhibited an overt bias as result of Stacey or Brad DeBungee’s Indigenous status. There was no evidence of blatant discriminatory behavior or of Staff Sergeant Harrison making utterances indicating that Indigenous status adversely affected his investigative decision-making process.

Without the existence of overt bias, to make a guilty finding, I must rely on the inference that Staff Sergeant Harrison’s investigation was negligent because of an unconscious bias toward Indigenous people. However, even though that is my conclusion, I have indicated it would be unacceptable to, on its own, make a guilty finding in relation to conduct stemming from an unconscious bias. Nevertheless, it does make sense to me that it is permissible to make a guilty finding in situations where the conduct resulting from an unconscious bias is so egregious, that the involved officer ought to have been aware that his actions were being negatively influenced by that unconscious bias, and/or, the results of that behaviour was so significant that the officer should have been alerted to its existence

Staff Sergeant Harrison testified that he knew this incident would generate media attention and public interest. The Agreed Statement of Facts noted that the Inquest into the Deaths of Seven First Nations began on October 5, 2015. The Inquest was ongoing at the time of this incident and the officers at the Thunder Bay Police Service including Staff Sergeant Harrison, were aware of it. One would think that he would be on high alert, that the significant public interest at that particular moment in time, would encourage and motivate him to ensure a thorough investigation was completed.

I cannot understand, how or why Staff Sergeant Harrison concluded as quickly as he did, that alcohol contributed to Stacey DeBungee's death other than reliance on his conscious or unconscious bias linking it to his Indigenous status. According to the evidence, including that of Staff Sergeant Harrison, while he was at the scene there was no evidence whatsoever of alcohol consumption. There was of course, evidence from Mr. Chartier that he had observed intoxicated people in the area the previous night, but I have accepted that that information was never relayed to members of the Criminal Investigation Branch. All that Staff Sergeant Harrison knew, was that Stacey DeBungee had previous *Liquor Licence Act* infractions, which begs the question, how did he take the leap from that, to therefore, Stacey DeBungee must have been drunk to such an extent that he passed out, rolled into the river, and drowned. I suggest that it is more than just likely, that he took Mr. DeBungee's Indigenous status into account when coming to such a conclusion.

This may or may not have been a conscious decision, there is no way to know with any degree of certainty, but considering his extensive experience as a criminal investigator, Staff Sergeant Harrison ought to have known this conclusion was not evidentiary based. He must have known that a comprehensive investigation was warranted. Staff Sergeant Harrison testified that upon reading the post-mortem report later, even then he did not consider taking investigative steps to determine how Stacey DeBungee got in the water. This is beyond worrisome; it is incomprehensible that an experienced investigator was satisfied with the mere assumption that a sudden death was accidental when there was absolutely no evidence to indicate how Stacey DeBungee actually came to be in the river.

In the matter of *Shaw v. Phipps*, 2010 ONSC 3884 (CanLII), the Court noted:

> Courts in Canada have accepted that racial profiling by police occurs in Canada and have indicated their willingness to scrutinize seemingly "neutral" police behaviour to assess whether it falls within the phenomenon of racial profiling. In *R. v. Brown* (2003) 64 O.R. (3) 161 (Ont. CA) at para. 9, Morden J. A. stated that the Crown's concession that the phenomenon of racial profiling existed was "a responsible position to take because…this conclusion is supported by significant social science research". In *Peart v. Peel Regional Police Service Board*, [2006] O.J. NO. 4456 (Ont CA), Doherty J.A. stated the "racial profiling occurs and is a day-to-day reality in the lives of those minorities affected by it."

In the mater of *Toronto (City) Police Service v. Phipps*, [2012] OJ No 2601, 2012 ONCA 155, the Court stated:

> The Adjudicator's reasons are also challenged on the basis that they arrive at a conclusion of discrimination based on “unconscious discrimination.” The appellants argue that this concept improperly imposes a burden of disproof on Constable Shaw. However, this was not a case where the Adjudicator concluded, without supporting evidence, that because discrimination can be unconscious, Constable Shaw unconsciously discriminated against Mr. Phipps. Indeed, the Adjudicator did not assume discrimination, but drew an inference of discrimination from a number of different pieces of evidence.
>
> As the Adjudicator observed, in any event, proof of Constable Shaw's subjective intention to discriminate is not a necessary component of the test. There is seldom direct evidence of a subjective intention to discriminate, because “[r]acial stereotyping will usually be the result of subtle unconscious beliefs, biases and prejudices” and racial discrimination “often operates on an unconscious level.” For this reason, discrimination is often “proven by circumstantial evidence and inference” (at paras. 16 and 18). See also *Radek v. Henderson Development (Canada) Ltd*. (No. 3), 2005 BCHRT 302, [2005] B.C.H.R.T.D. No. 302, at para. 482.
>
> The Divisional Court majority concluded that the Adjudicator was entitled to and, indeed, obliged to “draw reasonable inferences from proven facts” about Constable Shaw’s actions and whether Mr. Phipps’s colour was a factor in those actions (at para. 75). In rejecting the argument concerning an improper use of “unconscious discrimination,” the Divisional Court majority explained at para. 81 that its conclusion was not based on “Mr. Phipps’ perception of racism,” but on the Adjudicator's appreciation of all the evidence it accepted after rejecting “the evidence that the conduct of Mr. Phipps should have aroused the suspicion of the police of potential illegal activity.” It was on this basis that the Adjudicator arrived at a finding of discrimination: The Tribunal found that the most rational explanation for the actions of [Constable] Shaw was that they were motivated by race - that is, Mr. Phipps was an unknown black man in an affluent neighbourhood, and, therefore, he may be disguised as a postal worker, acting for an improper or illegal purpose.

There is no doubt whatsoever in my mind that Staff Sergeant Harrison decided very early on that the death was nonsuspicious. I am equally convinced that because the deceased person was Indigenous, found in a river where other Indigenous men had been found drowned, with a high level of alcohol in their system, he assumed the very same circumstances must have therefore existed in this case.

Frankly, there is no other reasonable explanation for such a shoddy investigation, one that was less than substandard from the very beginning. Staff Sergeant Harrison was more than capable of properly and thoroughly investigating the sudden death of Stacey DeBungee. No one saw Stacey DeBungee fall into the river, I question how Staff Sergeant Harrison immediately concluded the death was nonsuspicious which required virtually no investigation whatsoever if Indigenous status was not part of that consideration? To this day, how Stacey DeBungee came to be in the river has never been explained, yet Staff Sergeant Harrison immediately concluded that the death was nonsuspicious, and he has never wavered from this position. Stacey DeBungee's death is unexplained because how he got into the river has not been established; the Thunder Bay Police Service, specifically Staff Sergeant Harrison was duty bound to investigate accordingly.

As noted, I agree that it is a fundamental requirement for punishment resulting from this process, that there must be a blameworthy act. *Phipps* was an Ontario Human Rights Commission matter where individuals can be held liable for unconscious biases. In this case, the evidence shows that Staff Sergeant Harrison's negligent investigation was so egregious that it should have been apparent to him that his investigation was deficient to such an extent that he was committing misconduct; he should have asked himself why his investigation was so deficient, and then remedied the situation.

Staff Sergeant Harrison was fully aware that the Inquest into the Deaths of Seven First Nations was occurring in Thunder Bay at the very time of this incident. Racism within the ranks of the Thunder Bay Police Service was being publicly scrutinized at the exact moment he was tasked with this investigation which ought to have raised Stacey DeBungee's Indigenous status to the forefront. He had to be aware that the public would likely be interested in the outcome of this investigation and had to have known he was dutybound to treat the sudden death as a potential homicide. Instead, he prematurely concluded that the sudden death was somehow nonsuspicious; he failed to properly manage the scene, failed to ensure key witnesses were formally interviewed and failed to review reports. He should have questioned whether the quality of his investigation was influenced by Stacey DeBungee's Indigenous status. His failure to recognize this in my opinion, amounts to a blameworthy act.

I find the behaviour of Staff Sergeant Harrison amounts to discreditable conduct because, with respect to police services he was duty bound to provide, he failed to treat the investigation equally, without discrimination due to Stacey DeBungee's Indigenous status. Although it is not necessary to consider it, nonetheless, I find that a reasonable, impartial, and fully informed member of the public would find that Staff Sergeant Harrison's conduct would bring discredit to the reputation of his employer. As noted in the Broken Trust report, policing success relies on a strong and trusting relationship between the police service and the community they serve. Behaviour of this nature beaches that trust and adversely affects the reputation of the Thunder Bay Police Service.

Although I was not influenced by the findings in the Broken Trust Report in relation to their review of other sudden death reports, it is interesting that I came to a similar conclusion: Staff Sergeant Harrison failed to treat or protect the deceased and his or her family equally and without discrimination because the deceased was Indigenous; there are no explanations that account for the failings in this case; the failure to conduct an adequate investigation including the premature conclusion that the death was nonsuspicious is, at least in part, attributable to an unconscious bias.

Conclusion

In this case, to make a neglect of duty guilty finding, I must be satisfied on clear and convincing evidence, that the officer(s) were required to perform a duty, that without lawful excuse the duty was either wilfully not performed or was not performed diligently or promptly. The negligence must be more than a mere performance issue to amount to misconduct. When considering the evidence, I must refrain from applying the benefit of hindsight, I must consider the circumstances under which the officer(s) exercised their discretion or judgment.

In his testimony and in his report, Mr. Perry opined that the sudden death of Stacey DeBungee should have been deemed suspicious and treated accordingly. He noted it is always prudent for an investigator to avoid assumptions and to treat a death as suspicious until evidence shows otherwise. This is an accurate assessment, but one does not need Mr. Perry's background to understand this philosophy, it is basic police work. Staff Sergeant Harrison testified that he always held out that the matter could be suspicious in nature, but if there was truth to that assertion, his investigation would have reflected it. Instead, he did not treat the sudden death of Stacey DeBungee as a potential homicide, he failed to take the necessary and obvious steps to conduct a through sudden death investigation to such an extent, that it amounted to neglect of duty.

I find the evidence overwhelmingly supports the assertion that Staff Sergeant Harrison held a duty and failed to perform that duty without lawful excuse. The extent of that negligence exceeds that of a mere performance issue. Conversely, I find Sergeant Whipple was not duty-bound to perform a requisite duty as listed in the Notice of Hearing. Furthermore, I find that Sergeant Whipple was not in a position of responsibility necessary to consider his conduct discreditable.

In the Broken Trust Report, Mr. McNeilly stated:

> …Some of these disturbing attitudes related to the conduct of death investigations, and in particular to the assessment of whether the death of an Indigenous person is deemed suspicious…

I am not impacted by this particular finding, but I have come to the same conclusion with regard to the actions of Staff Sergeant Harrison based on the totality of the evidence before this tribunal. I find Staff Sergeant Harrison was affected by an unconscious bias, which resulted in him failing to treat the Stacey DeBungee sudden death investigation equally, without discrimination with respect to police services because of his Indigenous status. The resulting negligent investigation was so deficient, that he should have been aware that his conduct was adversely affected by an unconscious bias.

Decision

Staff Sergeant Harrison and Sergeant Whipple face two counts of misconduct; each count has been considered on its own merit. I assessed the testimony of all witnesses, considered the exhibits tendered including jurisprudence, and the submissions of counsel prudently and judiciously.

I make the following finding concerning the alleged misconduct of Staff Sergeant Harrison:

Count #1: Neglect of Duty - Guilty
Count #2: Discreditable Conduct - Guilty

I make the following finding concerning the alleged misconduct of Sergeant Whipple:

Count #1: Neglect of Duty – Not Guilty
Count #2: Discreditable Conduct – Not Guilty

_____
Greg Walton
Ontario Provincial Police, Superintendent (Ret.)
Adjudicator

Date electronically delivered: July 19, 2022

APPENDIX A

The following exhibits were tendered during this hearing:

1a) Delegation of Authority - Walton
1b) Delegation of Authority - Walton
1c) Delegation of Authority - Walton
2a) Prosecution Designation – Bordeleau
2b) Prosecution Designation – Bordeleau
2c) Prosecution Designation – Bordeleau
3a) Prosecution Designation – Dubois
3b) Prosecution Designation – Dubois
3c) Prosecution Designation – Dubois
4) Agreed Statement of Facts
5) Book of Documents – Volume I
6) Book of Documents – Volume II
7) Book of Documents – Volume III
7a) Tab 64 – Broken Trust report
7b) Tab 65 – Thunder Bay Police Services Board Investigation – Final Report
8) Notes of Detective Primmer
9) Photograph of Stacey DeBungee
10) USB Drive – Scene video and photographs
11) CV – Perry
12) Supplementary Occurrence Report
13) Book of Authorities – Butt
14) Oral submissions outline – Butt
15) Book of Authorities – Dubois
16) Transcript – Harrison – Volume I
17) Transcript – Harrison – Volume II
18) Book of Authorities – Volume I – James
19) Book of Authorities – Volume II – James