

Later the same day, E was at the hospital emergency room for a family matter and encountered Ms. E.F. on a stretcher drinking Listerine. She spoke to Ms. E.F. who told her that she drinks because she has nightmares. She said that the nightmares stemmed from an incident where Ms. E.F. was drinking by the creek in the inner city where homeless people drink. She got into a scuffle with a male whose first name she identified. He ended up in the water. She tried to pull him out, but was unable to do so. He floated away and died.

E resided elsewhere, but was visiting Thunder Bay. She provided her cell phone number to police. On May 13, 2016, an officer was directed to contact E and obtain a detailed statement from her. Some attempts to call E failed. She was only interviewed by police on June 30, 2016. She essentially repeated the account previously reported to police.

Ms. E.F.'s death may or may not have been related to intoxication (blood alcohol level of 244 mg/100 mL) leading to hypothermia. Ms. E.F.'s recent injuries may or may not have been attributable, in whole or in part, to stumbling or crawling. However, the investigation fell significantly short of what was required to enable those conclusions to be drawn.

The Adequacy Standards Regulations for police in Ontario set out legal requirements for all aspects of policing in Ontario. In relation to criminal investigations, these directives are found within the Criminal Investigation Management Plan (CIMP) Manual, which include guidelines for the effective investigation of found human remains. Police services are required to develop and maintain policies in line with this manual. The regulations also mandate the use of Major Case Management in

certain circumstances. The Major Case Management protocol is to be used for "occurrences suspected to be homicides involving found human remains."

The model is designed to ensure thorough, concise and consistent investigations of cases falling within its mandate. It represents best practice to implement relevant aspects of Major Case Management in cases that may be borderline in being identified as a mandated or "threshold" offence investigation.

The model was not employed in investigating Ms. E.F.'s death. Even where the model is not employed, sudden deaths in similar circumstances must be investigated in a thorough and efficient way, without unwarranted preconceptions.



We identified several deficiencies in our review of the investigation into Ms. E.F.'s death. (Most, if not all of these deficiencies were common to multiple sudden death investigations we reviewed.) As a result, it cannot be said that the investigative conclusion can safely be relied upon, without further work.

The discovery of a 30-year-old deceased woman in a wooded area with her pants partially pulled down and personal items, possibly belonging to the deceased, strewn about, compelled police to treat this as a suspicious death unless and until foul play could reasonably be excluded. A male was seen leaving the area just prior to Ms. E.F.'s body being discovered. A male was also observed viewing the investigation of the scene from a place of concealment. This was known information on the day that Ms. E.F. was discovered.

The police appropriately decided to secure the scene pending the results of the autopsy. The coroner also appropriately decided to order an autopsy be conducted in Toronto. These steps were consistent with the matter being treated as a potentially suspicious death. However, the approach taken more generally was incompatible with the matter being seriously investigated as a potentially suspicious death.

The scene was taped off and held. However, the investigative file was unclear as to whether Ms. E.F. was found on her back or on her stomach. Officer reports gave varying accounts. Some suggested that Ms. E.F. was moved by paramedics. Some suggested that the attending coroner moved the body. The photographs depicted Ms. E.F. on her back. No photographs were taken after Ms. E.F. was removed from the scene. The TBPS investigation did not clarify whether or not her pockets were turned inside out by attending emergency personnel. A list of exhibits seized from the scene was not provided or indicated in the investigative file supplied to the OIPRD. The file did not indicate forensic examination of anything seized, other than toxicological testing of Ms. E.F.'s blood.

The coroner determined when the body should be removed from the scene. The lead investigator was at the scene, but left to return to headquarters to create a media release. Upon his return, the body had already been removed.

It is accepted best practice in Ontario that when the police are investigating a suspicious death, as this clearly was, the police take the lead role and the coroner a secondary role. Police bear the ultimate responsibility of processing a potential crime scene and ensuring that all relevant evidence is collected, or otherwise memorialized. Once the scene is released it cannot be regained. Ms. E.F.'s death was only one of a number of cases in which the coroner made decisions better made by, or in consultation with, criminal investigators.



Of equal concern was the Regional Coroner's advice, as reported by police, that officers need not attend the autopsy based on his view that the circumstances of Ms. E.F.'s death were not suspicious. It was not within the Regional Coroner's mandate or expertise to characterize the death as non-suspicious, especially prior to the autopsy or any forensic examinations. It was also unwise to discourage the police from attending the autopsy.

We have identified, as a systemic issue, the lack of communication between pathologists and TBPS investigators, resulting in incomplete information conveyed to the pathologist, and in insufficient case conferencing between the pathologist, coroner and investigators. The absence of any officer at Ms. E.F.'s autopsy could only exacerbate this lack of communication. Failure to attend the autopsy deprived investigators of the deceased's clothing for later forensic examination, first-hand knowledge of the injuries found, and the opportunity to put various theories and scenarios to the pathologist, including questions as to what role the injuries might have played short of causing death.

It was the coroner who communicated the autopsy findings to the lead investigator. If recorded accurately by police, it appears that the coroner failed to accurately outline the full range of injuries suffered by Ms. E.F. and also appeared to overstate the pathologist's opinion as ruling out foul play.

It is important that investigators have an accurate and timely understanding of the autopsy results, especially when the formal autopsy report will not be forthcoming

immediately. In particular, there appeared to be no documented discussion on how to reconcile the full range of injuries, including head and chest injuries suffered by Ms. E.F. with the other evidence in the case. There is no indication that investigators considered whether the injuries described in the autopsy report could have contributed to a loss of consciousness, and if so, whether they could have been inflicted by someone.

No documentation was obtained by police of any prior resuscitation attempts which might explain the fracture to Ms. E.F.'s sternum or any steps taken by police to ascertain whether such documentation existed. The investigative file provides no insight as to whether this was mere speculation on the pathologist's part or was informed by records provided to the pathologist.

Investigators became aware that a male who was reportedly with Ms. E.F. shortly before her death may have lied when interviewed by police. They also became aware that Ms. E.F. allegedly confessed that she was complicit in someone else's death. There is no documented consideration given to how this information might impact on the investigation into Ms. E.F.'s death – for example, was Ms. E.F.'s death associated in any way with her alleged involvement in another death? The citizen who first reported Ms. E.F.'s remains to police was never interviewed in detail or in a formal, recorded format as to her observations. The civilian who reported that she and her husband had seen and described a male observing the investigation of the scene from a place of concealment was never interviewed by police at all. Nor was her husband. Nor was the security guard who came forward.

Other deficiencies included the following:

- A failure to establish a chain of command at the scene. Nobody appeared to take command of the investigative steps taken at the scene
- A failure to determine conclusively if the body was moved and by whom and why
- A failure to determine conclusively if Ms. E.F.'s pockets were turned inside out and if so by whom and why
- A failure to examine and thoroughly investigate items found near the deceased to determine any linkage to Ms. E.F. or persons of interest arising from those items
- A failure to obtain the deceased's medical records specifically linked to her recent hospital visits to determine whether the fractured sternum could be linked to resuscitation efforts
- A failure to obtain complete paramedic reports and statements from attending paramedics
- A failure to attend the retail store and the adjoining area in an effort to identify, through witnesses or video, who was with the deceased prior to her death
- A failure to re-attend the scene at hours where regular visitors could be expected to identify witnesses/suspects
- A failure of the lead investigator to review reports submitted by officers on the file
- A failure to determine conclusively what property scattered about the area belonged to Ms. E.F.

Based on the OIPRD's interview of the lead investigator, it was obvious that over-reliance was placed on the opinion of the coroner throughout the investigation. There also appeared to be little or no consideration of whether the documented injuries to Ms. E.F. could have contributed to her loss of consciousness, though not themselves fatal. This is yet another case in which police focused only on whether the injuries were themselves fatal.

This death should be the subject of reinvestigation.



## Case Review – G.H.

On March 25, 2015, at approximately 9 a.m. police and emergency personnel were called to the pathway near 60 North Junot Avenue. A passerby had located a body (later identified as 20-year-old G.H.) in the snow a few feet off the pathway.

Thunder Bay Fire Rescue personnel arrived prior to the police, and confirmed death. According to an occurrence report, Fire Rescue personnel advised the first TBPS officer to respond to the call that it appeared the deceased had possibly been in a fight. EMS personnel arrived and were asked to stay back by a uniform patrol officer who indicated that the scene was being protected as it was undetermined at that time whether it was a crime scene.

The area where Mr. G.H. was found was snow covered except for the paved path, which was clear. The temperature was reported as -1 degree Celsius. The body was in the fetal position dressed only in pants and socks. Mr. G.H.'s shirt, shoes and other belongings were scattered in the vicinity of where he was located.

A forensic identification officer arrived and took photographs at the scene and set out exhibit markers. Exhibits included clothing – some with blood staining and blood spots at multiple locations, including droplets in the snow. Officers noted footwear impressions near the body. These were not followed up on since officers presumed that they had been made by Fire Rescue personnel.

At 10:38 a.m., the coroner arrived on the scene. The coroner indicated “[t]he deceased had several abrasions on his body which appeared to be consistent with a fall including abrasions on the left eyelid and nose, left and right shoulders and right forearm.” The coroner also noted tattoos on the body. The coroner identified the body as G.H., by an Ontario photo health card in the back pocket. An officer confirmed the identity with a photo from the police Niche system.

The coroner left the scene at 11:03 a.m., having given the body identification tag to a constable to give to the funeral home body removal service. The forensic identification officer left the scene at 11:33 a.m. When the forensic identification officer returned at 12:10 p.m., the body had already been removed to be transported for the autopsy. No seal had been placed on the body bag.

Officers at the scene advised the forensic identification officer that the funeral home attendants told them that they had seen a jacket next to a garbage can where the walkway intersects with Red River Road. Officers then located the jacket and hoodie, which were seized and photographed. All other exhibits were also seized.

At 11:05 a.m., the forensic identification officer and investigators met at the police station. The forensic identification officer provided the deceased's identity and indicated that both she and the coroner believed the cause of death to be hypothermia. She noted that there were no major signs of trauma: “Minor scratches

appeared to have been made by bushes in the area to which his footprints were backtracked. With the advanced stages of hypothermia, the body believes that it is hot and people tend to start stripping off clothing.”

Between 1 and 2 p.m., two officers canvased residences in the area where the deceased was found. This did not yield helpful information.

At 1:25 p.m., investigators began attempts to contact the next-of-kin. At 5:30 the next-of-kin had been notified of the death.

At 2:30 p.m., two forensic identification officers attended the autopsy. They took photographs and seized the deceased’s clothing. They noted that the deceased had a crushed beer can down the front of his pants. The investigation file the OIPRD received did not contain any further comment or note on the beer can. The pathologist advised the officers that there was “no sign of foul play or trauma and no anatomical cause of death pending toxicology results.”

At 5:14 p.m., the lead investigators released the scene, indicating to officers holding the scene that the autopsy had been completed and foul play was not suspected.

Photographs were taken during the autopsy, which show obvious injuries to Mr. G.H.:

- Fresh abrasions and blood on the left wrist, hand, arm and shoulder
- Fresh abrasions on the back
- Fresh abrasions on the right leg and knee
- Fresh abrasions on the left leg and knee
- A bleeding contusion over the left eye
- Blood from the nose

While these injuries are obvious in the photographs and some are listed in one of the forensic officer’s notes, they are not listed in any police report.

The autopsy report, dated July 3, 2015, was not included in the case investigation file and had to be requested separately. The report noted the pathologist reviewed photographs of the scene prior to conducting the autopsy. The autopsy reported noted the following fresh abrasion injuries:

- Above the left eyebrow with a bruise
- On the nose
- On the tops of both shoulders
- On both knees
- On the left wrist and hand
- On the right elbow and forearm
- A bruise below the left knee

The cause of death was listed as "hypothermia." Other significant conditions contributing to the death but not causally related to the immediate cause, listed "elevated blood ethanol concentration." The toxicology report listed Mr. G.H.'s blood alcohol level as 285 mg/100mL.

An individual (B) attended the police station on March 26, 2015. She stated that she had received two text messages the previous day from an unknown person linked to a phone number she provided to police. The second message read, "Stop MURDERING people and hiding them in Junot Park [name deleted]!" A police report with this information was logged, but there is no indication in the investigative file of any follow-up.

On March 31, 2015, an investigator was assigned to look into an incident regarding the death of Mr. G.H. He was told that a call history at the Thunder Bay police station revealed that an individual (C) called police at 10:53 p.m. on March 24, 2015, indicating that Mr. G.H. was intoxicated and yelling in the park. C indicated that Mr. G.H. was a friend, that C was calling from Mac's on Red River Road and that he was not remaining at the scene. The investigator could not locate C that day.

On April 4, 2015, C was put on the Major Occurrence Bulletin to contact Criminal Investigations Branch. On April 6, 2015, C contacted police with a residential address where they could speak to him. Police attended the residence and brought C and another man (D), out to the police car where an interview took place while they remained together. The interview was audiotaped. Only a statement for C was prepared. It does not appear that D was asked any questions.

C stated that he had known the deceased since 2007. He could not recall exactly which date the incident occurred. The investigator reminded him of the date. C said that he met up with Mr. G.H. at about 2:30 p.m. They went to Mr. G.H.'s girlfriend's residence (though he was unable to supply her name). They then met up with D. They obtained some liquor and D became so drunk that they called an ambulance. The police came as well. C and Mr. G.H. then met up with C's girlfriend E. (She was never interviewed) C pawned E's cell phone and bought more alcohol. Eventually, they met up with D again, C's girlfriend bought more alcohol and the four of them went to Junot Park to consume it.

C stated that Mr. G.H. was getting rowdy, yelling and running around the trail without his shirt on, yelling or swearing at passersby. C told police that this was typical for Mr. G.H. C, his girlfriend and D left. They called the police to advise that Mr. G.H. was out of control and provided his location. They did not leave any alcohol with Mr. G.H. C did not feel Mr. G.H. would pass out. (C subsequently died as a result of injuries suffered in an unrelated incident.)

This is but one of a number of cases in which an Indigenous person was presumed by TBPS to have died suddenly as a result of hypothermia or drowning. In a number of these cases, police failed to recognize that findings of hypothermia or drowning did not relieve them of their obligation to determine the circumstances under which these individuals froze to death or drowned, including the role, if any, played by others in contributing to their deaths. In some instances, police had information that may or may not have ultimately led to a different finding, but was not pursued. Police too quickly presumed that these sudden deaths of Indigenous people were accidental, where there were no obvious evidence of foul play. This approach does not inspire confidence that the investigations were thorough, effective and bias-free.

In Mr. G.H.'s death, police engaged in investigative work not necessarily done on similar cases. The pathologist who conducted the autopsy appeared to support the conclusion that the evidence did not support foul play. Nonetheless, there remained significant deficiencies in how this investigation was conducted and completed. These included:

- No criminal investigators attended the scene while the body remained and so were poorly situated to direct the investigation. It was not appropriate for the coroner to direct the removal of the body before investigators had even arrived at the scene or had signed off on the completeness of the forensic work done at the scene. This is yet another instance in which forensic identification officers received little or no direction

from investigators. In response to this concern, a lead investigator told us the forensic identification officers "know their job pretty well." With respect, the concern is not motivated by lack of expertise on the part of the forensic identification officers, but on the many instances that we saw in which the forensic identification officers were unaware of information known to investigators that was relevant to the performance of their duties.

- The body was removed without being secured by seal and without investigators or the forensic identification officer present. This was unacceptable.
- A forensic identification officer reported that footprints observed near the body were made by firefighters and paramedics. No steps were taken to preserve these footprints for comparison purposes and to eliminate first responders. The evidence was insufficient to conclude that the footprints were inevitably made by first responders.
- A forensic identification officer told investigators in a post-autopsy meeting that she and the coroner believed that the deceased died of hypothermia and that footprints leading from nearby bushes accounted for the minor abrasions on the deceased's body. Any such footprint trail remained undocumented and unanalyzed in the officer's reports. Nor was it captured in photographs. Undocumented findings prevent evaluation of the evidence, oversight and review.



- The forensic identification officer's report also indicated that the numerous visible injuries were consistent with a fall. However, the blood observed in the snow was of droplets, which might be inconsistent with that theory, or at least invite consideration of the theory, together with ongoing consultation with the pathologist. There is no indication that consideration or consultation took place. As well, there is no indication in the investigative file that any blood samples were submitted for analysis, and compared to the deceased's blood.
- None of the exhibits seized from the scene were subjected to any forensic examination or testing.
- Police obtained a statement from a single witness (C). He was interviewed in the back of a police vehicle, and in the presence of a person who was apparently also with the deceased shortly before his death.<sup>177</sup> He was never asked the most rudimentary questions about his knowledge. The questioner failed to draw upon the evidence collected at the scene, for example, in exploring what, if any injuries were observed by C. By the time C was interviewed, it can reasonably be inferred that investigators had already decided that Mr. G.H.'s death was accidental. In fact, the same date the interview was being conducted, arrangements were being made to return personal items seized as exhibits to Mr. G.H.'s family.
- Other individuals known to be with the deceased shortly before his death were never interviewed. Nor does the investigative file document any efforts to contact them.
- Despite information provided to police by B, she was never interviewed by investigators. Nor did police engage in the most rudimentary steps to investigate the text messages sent to B.
- The emergency first responders were never interviewed.
- The coroner's opinion appeared to figure too prominently in the assessment by police as to what happened here.

Based on our interviews, it was evident that at least two investigators on this file failed to have a complete understanding of how the deceased's injuries had to be considered. The location where Mr. G.H. was last seen is a place that was known to those officers as an area where people consume alcohol and are subjected to assault by others. One officer described to us a 2010 homicide there. However, he reflected that "injuries have to be more than superficial things to cause a death." He similarly observed that people may fight, but evidence is required to connect a fight to a death. He felt a case is particularly problematic when nobody is saying, "saw this." My view is that police should not be solely concerned with whether injuries were fatal (i.e., actually caused the death). Police also need to consider whether injuries resulting from a fight could have rendered a deceased person unconscious, allowing him or her to succumb to hypothermia. On several files, investigators failed to appreciate this heightened importance of injuries.

Regarding the G.H. investigation, it was deeply troubling that police were called by C at 10:53 p.m. on the evening Mr. G.H. was last seen alive. C stated that Mr. G.H. was being left alone in Junot Park and that he was intoxicated and needed to be checked on. The investigative file contained no information as to how this call, if at all, was responded to. TBPS advised us that the call was logged as being of a lower priority due to the fact that it came in on the mainline and based on the limited details given. It was felt that there was no indication of public safety issues or immediate danger to Mr. G.H. So the call went unanswered for some time, as priority calls kept coming in. At some point in the night, a cruiser drove by Junot Park and nobody was observed. This was reported

back to dispatch and the car was cleared to leave. TBPS brought this matter to our attention and advised that steps have been taken to address the inadequate response to this call. We were told that the police chief met with the Grand Chief of Nishnawbe Aski Nation, and contacted the regional coroner as well, ultimately leading to a change in policy on how these calls are dealt with. We have not taken steps to audit TBPS's responses to such calls.

The investigation into G.H.'s death was deficient in important areas. This prevents a proper determination as to whether it was or was not attributable to accident and unrelated to foul play. A reinvestigation is required.

## Case Review – I.J.

I.J. was a 57-year-old Indigenous woman. Her body was discovered by a passerby on March 21, 2017, at approximately 3 p.m., on the icy pavement behind the Canadian Tire Store at 939 Fort William Road. The investigation would reveal that she had been released from hospital approximately 36 hours earlier after being taken there by police under the authority of the Mental Health Act, following a call to TBPS by her ex-partner (B).

Ms. I.J. was found lying on frozen ground dressed in jeans, a T-shirt, a hoodie and a hooded jacket. She had her left shoe on and her right shoe was located approximately one metre away. There was a full upper denture plate located on the ground behind her body that appeared to have blood on it. A change

purse and numerous coins were strewn on the ground near her head. Her body was lying on a blue identification folder, which contained information that confirmed her identity. Ms. I.J. had a clump of hair gripped in her left hand. The knuckles of her left hand had fresh abrasions and cuts. One of the forensic identification officers told the OIPRD that one of Ms. I.J.'s knuckles appeared as though she may have hit someone in the face because the marks on her hand looked almost like teeth.

Numerous items were seized at the scene, including papers from the District of Thunder Bay Social Services Administration with a name relating to another person (C) on them, along with apparent blood.

At the direction of the coroner, an autopsy took place in Toronto on March 24, 2017. The forensic pathologist itemized 23 abrasions, contusions and lacerations under "signs of recent injury." Ms. I.J.'s swollen left ankle was dissected to reveal a fracture. Blood and urine samples were taken for toxicological examination, which found a blood alcohol level of 291 mg/100 mL. The forensic pathologist determined the cause of death was "hypothermia and ethanol intoxication in a woman with a left ankle fracture."

The Thunder Bay Forensic Identification Unit officer who attended the autopsy in Toronto reported he took photographs of what he described as several minor bruises throughout Ms. I.J.'s body. He seized hair samples for comparison purposes, fingernail clippings, hand swabs and hair she had gripped in her hand. In interviews with the OIPRD, an investigator stated that this hair was determined to be her own; however, there were no reports included in the investigative file that confirmed this. The forensic identification officer reported that "there were no other signs of trauma located on I.J. There was no evidence of suspicious nature during the post."<sup>178</sup>

Police spoke to various potential witnesses. Some provided information about Ms. I.J.'s whereabouts in the days immediately prior to her death. A security guard at the Intercity Mall came forward to police, at her own initiative, to advise that she dealt with Ms. I.J. at the food court on March 20, 2017. Ms. I.J. was intoxicated and was escorted out and on to a bus just before 4 p.m. Ms. I.J. told the security guard that she believed people were following her and wanted to

take her money. She also indicated that it was the people she had been drinking with earlier. The security guard did not see anyone else at the time.

Her ex-common law partner (B) advised officers that Ms. I.J. was at his residence between 5:30 and 8 p.m. on March 20, 2017. He also stated that he had spoken to another man (D) who told him that he had been in Ms. I.J.'s company at the Intercity Mall food court at around 9 p.m. on March 20, 2017, and that he last saw her at that same location with another male (E). E confirmed to police that he sat with Ms. I.J. for 45 minutes between 7 and 9 p.m. She was counting her change, wanting to buy alcohol. She left by herself. Another individual (F) also came forward to police, at his own initiative, to produce an LCBO receipt dated March 20, 2017, that he found outside the LCBO. He believed that the receipt belonged to the deceased and that the store video might reveal who she was with at the relevant time.

An officer was assigned to canvas businesses, including the food court, for possible video evidence. We were provided with a video clip from the food court. An officer's note dated April 25, 2017, indicated that the video showed the interaction the security guard had with Ms. I.J. just before 4 p.m. on March 20, 2017. No other video was provided to us.

Our detailed review of the investigative file revealed a number of inadequacies in how this investigation was conducted.

The crime scene depicted in the photographs was not accurately or completely captured by attending officers describing the scene, including the investigators. Ms. I.J.'s belongings were scattered over a substantial area. Her money holder was open and coins were scattered about; a bloody denture plate was found as well as a clump of hair grasped in Ms. I.J.'s fist.

These observations required that this matter be dealt with as a suspicious death and that foul play not be discounted without a thorough investigation. These observations should have compelled the investigation of this case under the Major Case Management protocol. Instead, we found the investigative file incomplete in a variety of ways. Relevant documents and officer notes were not kept with the file and not easily retrieved. There was no clear structure to the investigation. It was unclear from the file who was even in charge at the scene. The file contains no evidence that an investigative plan was developed or implemented.

There is no indication that D was ever interviewed by police. One of the investigators happened to run across E on the street and spoke to him about his contact with the deceased. Although some information provided to police suggested that E was the last person seen with the deceased, he was never formally interviewed. The street discussion can only be described as superficial. E referred to two other people who were with the deceased at the food court on the date she was last seen.

There is no indication that their identities or descriptions were followed up on. Police also made no inquiries about the person (C) identified in papers found by the deceased's body. That person was never interviewed by police. A prescription pill bottle was seized at the scene. Despite the fact that the prescription number and issuing doctor could be read on the bottle, no steps were taken to ascertain the identity of the patient or any connection of that individual to the relevant events.

While TBPS provided us with relevant information pertaining to this systemic review, a common theme was that relevant information that should have been easily accessible through the investigative file was not available. There was often no systematic way in which developments in the investigation were noted. There were often few, if any, indications that anyone was overseeing, in any meaningful way, what had been collected, its significance and what items remained outstanding.

This was but one of a number of files in which the autopsy report and coroner's report were not contained in the investigative file, and had to be obtained elsewhere. These reports would have been retained in any investigative file created pursuant to Major Case Management and highlights one of the problems with TBPS's failure to designate major cases as such.

As previously indicated, samples were taken during the autopsy for submission to CFS for examination. The investigative file did not reflect what reports were received in response and any further investigative steps taken as a result. The inadequacies in the file

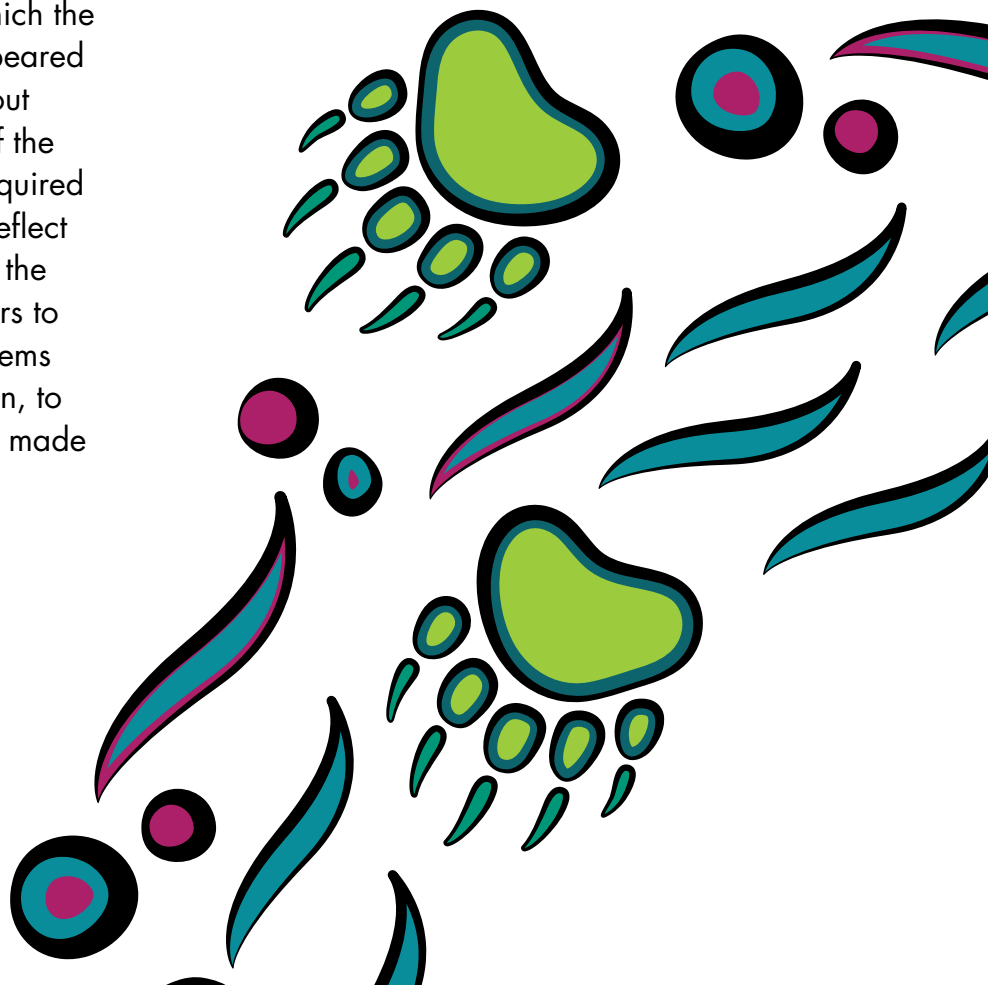
contents make oversight and accountability difficult, if not impossible. Plus, the state of these files hampers the ability of investigators to re-open cases, where appropriate, in an effective way or pursue additional leads that might become available.

The forensic identification officer reported that six groups of individuals viewed the deceased's body. The officer indicated that after each group, the officer viewed the deceased and noted no disturbance. Viewers were advised to not touch the deceased upon viewing. These visits took place prior to the autopsy. It would appear that these groups were allowed unsupervised access to the deceased's body, as the officer's notes indicate that the body was checked after each group viewed the body. This approach defeats steps taken to ensure continuity, and complicates any subsequent use of forensic evidence obtained from the body.

This again represented a case in which the cause of death – hypothermia – appeared to resolve the matter for police without appropriate scrutiny of the totality of the evidence and without completing required investigative steps. The file did not reflect any meaningful interaction between the pathologist, coroner and investigators to discuss the significance of specific items found at the scene, and their location, to ensure that informed decisions were made about the case.

Ms. I.J. had abrasions and bruises all over her legs and arms. She had a fractured ankle that would have made walking extremely painful. How did all this happen? It is possible that Ms. I.J. may have died of hypothermia, linked to intoxication and without the intervention of third parties. But this investigation was inadequate to so conclude.

The combination of a number of such cases leads to the conclusion that police were all too ready to look uncritically at these cases as "accidental deaths" or draw that conclusion too early in their work. This, in turn, meant that cases were presumed to be non-suspicious unless affirmative proof of foul play was discovered, when no such presumption should ever have been made. This treatment of multiple sudden deaths of Indigenous individuals reinforced the legitimacy of concerns about differential treatment by police of Indigenous deaths.



## Case Review – K.L.

On February 13, 2017, K.L., a 46-year-old Indigenous woman was struck by a pickup truck while crossing the street at the intersection of Marks Street North and Victoria Avenue East. The vehicle was making a left turn. As a result of being hit, Ms. K.L. suffered a broken leg and a concussion. Two days later, while she was in hospital recovering from surgery, the investigating officer served her with a Provincial Offence Notice under Thunder Bay By-Law 39(1) [Pedestrian enter highway from sidewalk not in safety]. The driver faced no charges.

The investigation into this incident was not a death investigation. However, TBPS's decision to charge Ms. K.L. heightened concerns, particularly in Indigenous communities, about over-policing of their members by TBPS, and differential treatment based on race. These concerns were probably exacerbated by some inaccuracies in the media account of events. Nonetheless, the case's importance in the ongoing relationship between TBPS and Indigenous communities required us to examine how the matter was investigated.

The investigation was conducted by an admittedly inexperienced uniform patrol constable. He obtained advice from a more senior traffic specialist before charging Ms. K.L. The investigation was deficient and ultimately flawed in a number of important ways.

The only portrayal of the scene was a diagram drawn by the investigating officer on the Motor Vehicle Collision Report. The diagram indicates that the vehicle that struck Ms. K.L. was initially facing a stop sign before proceeding into the intersection and making a left turn, which was when Ms. K.L. was struck.

There is no indication in the diagram or accompanying narrative as to whether or not there were stop lines or crosswalks marked on the roadway. Nonetheless, the diagram

shows that Ms. K.L. would have been struck within the area of the intersection normally contained within a marked crosswalk. The diagram indicates that Ms. K.L. was struck by the front of the vehicle in the process of its turn as she approached from the opposite direction.

The diagram contains no measurements, such as the dimensions of the roadway or the location of the impact. The investigating officer agreed, in hindsight, that such measurements should have been taken.

The Motor Vehicle Collision Report is a form provided by the Ministry of Transportation (MTO) and must be completed by police in specified circumstances, such as where injuries follow from a motor vehicle accident. MTO will issue a notice or notices to the police (as MTO did here) where a submitted

Motor Vehicle Collision Report is deficient. There was a process in place at TBPS to correct such reports when the MTO brought such deficiencies to the service's attention. My assessment of this investigation does not turn on the fact that MTO identified deficiencies in the completion of the Motor Vehicle Collision Report.

Several witnesses were interviewed. One of those witnesses was the driver of the subject vehicle, a pickup truck. His step-daughter was a passenger in the vehicle. The investigating officer allowed the step-daughter to prepare the driver's statement, rather than ensuring that he received an independent account from each. The investigating officer could not recall why he did not get a statement from her or why the driver was unable to prepare the statement himself.

The witness statement indicated that the step-father was unable to use his writing hand. The driver, in essence, stated that the pedestrian darted out to catch a bus while he was in the midst of turning. He maintained that he slowly crept out to see beyond a bus that was blocking his view and proceeded slowly with the turn. The investigating officer told the OIPRD that he would have questioned the driver about yielding the right of way, but he did not put everything said into the statement.

No formal statement was taken from Ms. K.L. The investigating officer provided this narrative that appeared to be attributed to Ms. K.L.:

- P1 – Noticed a Northwood bus stopped on the opposite side of the road
- Wanted to catch that bus to go home
  - Looked both ways to make sure it was clear, started to run
  - Started to cross the street and noticed a truck turning
  - Wave hand in a stopping motion to get driver to stop
  - Was hit by the vehicle turning and fell to the ground
    - Injuries – Broken right leg
    - Concussion
    - Vision problems in eyes

It is unclear that Ms. K.L. was even in a position to participate in the interview process, considering her concussion and existing injuries. The investigating officer chose not to ask her to sign a statement either at the scene or at the hospital considering she may have been in shock.

Several other witnesses confirmed that Ms. K.L. was rushing across the street to catch a bus when she was hit by the truck. The statements were vague and failed to address key issues relevant to what, if any, charges should be laid. The fact that a pedestrian was rushing across the street was far from determinative on the issue of liability. The investigating officer advised the OIPRD that the independent witnesses told him that Ms. K.L. darted in front of the truck, and that the accident was not the driver's fault. He raised this with his sergeant who advised him to get the witnesses to add this to their statements.

However, when the investigating officer met again with the witnesses he took no steps to have them amend their statements.

The investigating officer's diagram was also inconsistent with what the witnesses did say. For example, two witnesses stated that the pedestrian was struck by the driver's side front panel. The diagram indicates that the pedestrian was struck by the front of the vehicle. It was incumbent on the investigating officer to attempt to clarify or at least acknowledge these discrepancies and their impact on what conclusions should be drawn. It was of critical importance to determine, to the extent possible, what part of the vehicle struck Ms. K.L. This was relevant as to whether she was already in the crossing area when struck by the vehicle, especially given a driver's legal obligation to yield to a crossing pedestrian while turning.

The investigating officer provided the following conclusions in the Motor Vehicle Collision Report, based on his investigation:

"Vehicle 1 was stopped on R1 (Marks St. N.) facing northbound waiting to turn left to travel westbound on R2 (Victoria Ave. E.). Vehicle 1 was stopped while P1 was approaching the north side of R2 from the west side of R1. Vehicle 1 checked to make sure roadway was clear then proceeded to turn onto R2. P1 started to walk across R2 travelling southbound quickly to attempt to catch the bus. P1 did not allow the right of way to the vehicle turning onto R2. P1 was struck by Vehicle 1 while trying to cross the street."

When we interviewed the investigating officer, he initially felt that the video from the bus assisted in explaining his decision to charge Ms. K.L. However, the video shows Ms. K.L. approaching the intersection while the pickup truck was stopped, waiting to turn. It also shows the vehicle proceeding into the turn, but does not show it striking Ms. K.L. It was of little or no assistance to the investigation.

TBPS's conclusions were not supported in law or by the evidence the investigating officer documented. The narrative purportedly given by Ms. K.L. supported her compliance with the applicable by-law. According to TBPS, she allegedly violated the following subsection of the by-law:

39(1) Pedestrian Traffic Proper  
Pedestrian Crossing: Pedestrians shall not step from the sidewalk on to a highway without looking in both directions and unless it is safe to do so, and shall cross at an intersection, at right angles to the highway. Failure to comply with this section constitutes an offence.

One would have to reject her narrative in order to find that she violated this subsection. It is not clear that the investigating officer appreciated this at the time, although he did appreciate it when interviewed by the OIPRD. He acknowledged that Ms. K.L. said that she looked both ways before crossing, but that did not necessarily mean that she did. He said that he based his conclusion on all of the witness accounts – except that the witnesses did not appear to have been asked whether Ms. K.L. looked both ways before entering the crossing area.



It is of importance to note that the investigating officer stated that in his initial investigation, he considered only the Highway Traffic Act (HTA) and felt the driver was at fault. This changed after he consulted with the traffic office. Based on the traffic specialist's advice, the decision made by the investigating officer misapprehended or failed to adequately consider the applicable HTA provisions. These include the following:

### Where to stop – intersection

144(5) A driver who is directed by a traffic control signal erected at an intersection to stop his or her vehicle shall stop,

- a. at the sign or roadway marking indicating where the stop is to be made
- b. if there is no sign or marking, immediately before entering the nearest crosswalk or
- c. if there is no sign, marking or crosswalk, immediately before entering the intersection.

### Yielding to pedestrians

(7) When under this section a driver is permitted to proceed, the driver shall yield the right of way to pedestrians lawfully within a crosswalk.

The HTA defines crosswalk:

“Crosswalk” means,

- a. That part of a highway at an intersection that is included within the connections of the lateral lines of the sidewalks on opposite sides of the highway measured from the curbs or, in the absence of curbs, from the edges of the roadway, or
- b. Any portion of a roadway at an intersection of elsewhere distinctly indicated for pedestrian crossing by signs or by lines or other markings on the surface (“passage protégé pour piétons”)

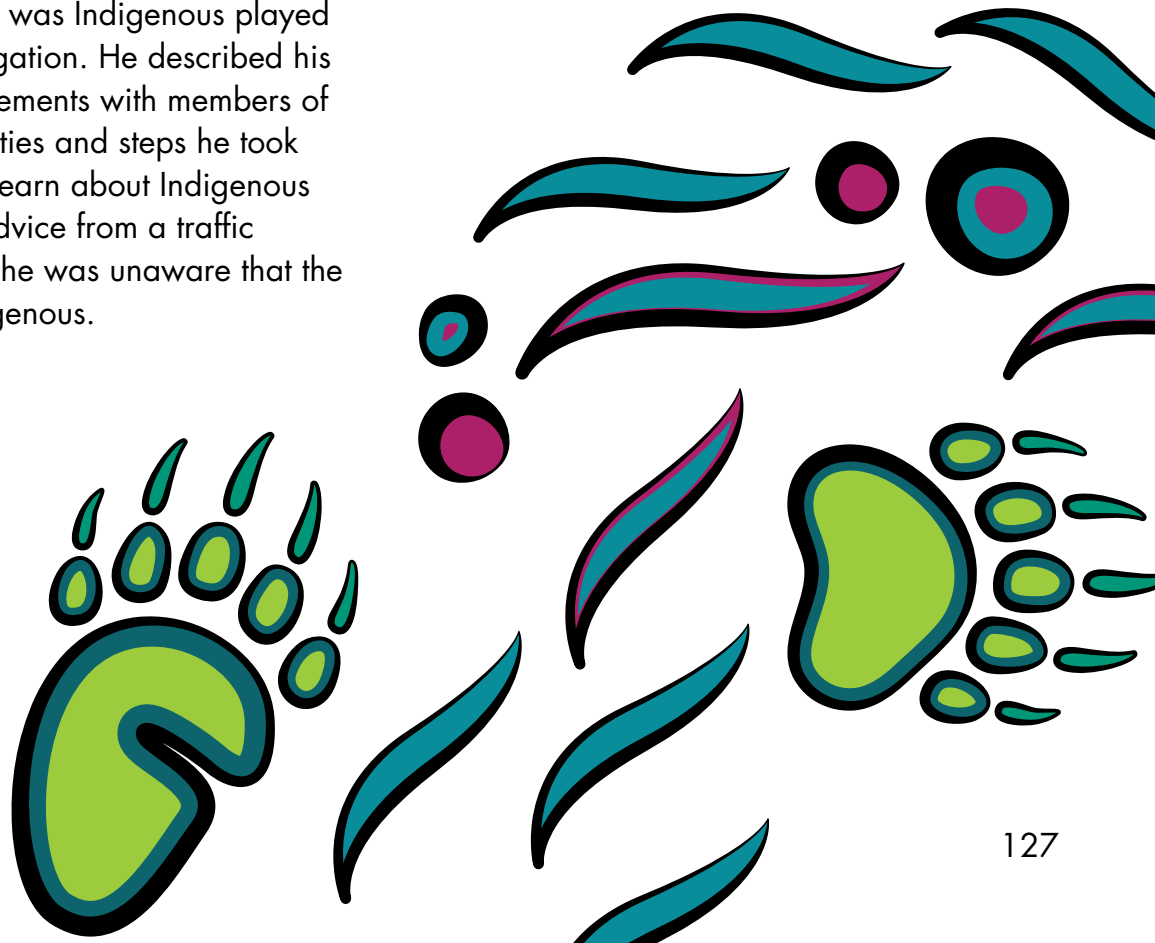
A driver has a statutory obligation to yield to a pedestrian lawfully within a crosswalk. There was no evidence that Ms. K.L. was outside the crosswalk area when she crossed the street and was struck. It was the driver's obligation to turn safely after stopping at the stop sign. The investigation failed to take adequate steps to determine precisely where the impact occurred, what part of the vehicle came into contact with Ms. K.L., and where Ms. K.L. was within the crossing area when hit. The fact that a pedestrian rushes across the street within a crossing area does not relieve the driver of his obligation to turn in safety.

There was an inadequate basis upon which the officer could charge Ms. K.L. (The charge against her was subsequently withdrawn by the prosecution). The key issue here was whether the driver was in violation of the HTA by failing to yield appropriately to a pedestrian. The investigation was inadequate to decide that issue. When interviewed by the OIPRD, the investigating officer identified lessons he learned from this case.

It was hardly surprising that members of Indigenous communities and others found TBPS's investigation deeply offensive. The notion that Ms. K.L., the pedestrian in this collision, was charged under these circumstances – and indeed charged while in the hospital – invited legitimate concern that she faced unequal or discriminatory treatment at the hands of the police. The failure to meaningfully consider the driver's potential liability here contributed to that concern.

The investigating officer told the OIPRD that the fact that Ms. K.L. was Indigenous played no role in his investigation. He described his prior positive engagements with members of Indigenous communities and steps he took prior to this case to learn about Indigenous culture. He sought advice from a traffic specialist who said she was unaware that the pedestrian was Indigenous.

I accept that the investigating officer was, at the time, inexperienced and sought advice on how to proceed. That advice was, in my view, poor. The decision to charge Ms. K.L. was legally questionable and in any event, demonstrated a questionable exercise of discretion. Its impact on Indigenous people was profound. It signalled to many (and reinforced their views) that a different policing standard applies to Indigenous and non-Indigenous citizens. In my view, TBPS should also have had in place a mechanism to deal proactively with the fallout arising from this case. This would include a well-established network with Indigenous leadership to address crises, and a fine-tuned communications strategy. My recommendations address these issues.



# Stacy DeBungee

As earlier indicated, the terms of reference for this systemic review reflected that the conduct investigation into Stacy DeBungee's death might uncover evidence relevant to the systemic review. However, it was important and procedurally fair that evidence collected pursuant to the systemic review not be used to advance the conduct investigation. Officers were advised, accordingly, that evidence they provided solely on the systemic review would not be used in relation to any conduct investigation. We have respected that distinction throughout.

TBPS's investigation into Stacy DeBungee's death revealed systemic failings. These were fully identified in OIPRD's Investigative Report, which was provided to the complainants as required by the Police Services Act. The Investigative Report was made public by the complainants shortly after it was provided to

them. I have reproduced here key findings of systemic importance contained in the Investigative Report, given their relevance to this review. However, I have not reproduced the detailed summaries of what various witnesses said, nor the names of either those witnesses or the officers who are also the subject of that report. Nor have I outlined in any detail the underlying facts, although I do provide, immediately below, a brief overview, as is necessary, to understand the findings that followed.

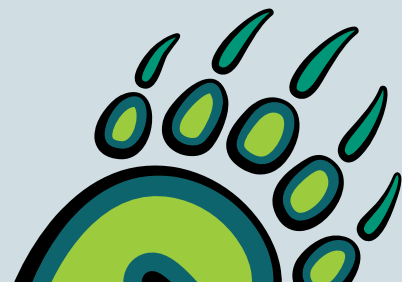
To be clear, the relevance of my findings relating to Mr. DeBungee's death to this systemic review are not dependent on whether individual officers were or were not guilty of misconduct. If the matter proceeds to a disciplinary hearing, the determination whether misconduct has been proven to the requisite degree of proof will be made by an adjudicator, not by me.

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

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

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

On October 21, 2015, one of the complainants, the deceased's brother, and others attended TBPS to request information about what happened to their family member and obtain answers about how he came to be in the river.



They spoke to three investigators. The officers told the family that Mr. DeBungee's death was not classified as foul play and that further information would be provided by the coroner.

When pressed with further questions, one of the lead investigators informed the family of a theory that Mr. DeBungee had passed out unconscious, simply rolled nine to 10 feet down the riverbank into the river and drowned.

The complainants believed that the investigating officers concluded that Mr. DeBungee's death was an accident prior to taking any meaningful investigative steps to determine the cause of death and how he ended up in the river. As a result of their lack of confidence in the investigation, they hired a private investigation agency to investigate the death.

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

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

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

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

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



The complaint to the OIPRD stemmed from the complainants' lack of confidence in TBPS investigators' rushed conclusion of what happened to Mr. DeBungee. They believed that the investigation was inadequate and relied, among other things, upon the deficiencies identified in the private investigation agency's Investigation report.

My findings included the following:

- This sudden death should have been treated as a potential homicide – and investigated as such. There was no basis to affirmatively rule out foul play based on observations made at the scene or even after the autopsy examination. It could be speculated that the death resulted from an accident (such as falling into the river while intoxicated) or criminal activity (such as the deceased being pushed into the river) or be explained by a number of other scenarios. However, such speculation was no substitute for an evidence-based and informed investigation.
- As several officers acknowledged, the absence of obvious trauma or injuries attributable to a physical altercation does not determine whether the death resulted from an altercation. Similarly, the determination that the deceased drowned, and that intoxication was a contributing factor in his death, is compatible both with accident and with criminal activity resulting in the deceased being pushed into the river.

- The coroner acknowledged that authorities did not know if the deceased was pushed into the river or fell in, which would be hard to tell without an eyewitness and only based on an autopsy. The autopsy revealed minor scratches and cuts on the deceased according to one of the forensic identification officers, which again would be consistent with either an accident or criminal intervention.
- Several officers showed a deeply troubling misconception about what a criminal investigation entails. Several officers asserted that there was no evidence of foul play or suspicious circumstances. They believed that, as a result, it remained essentially a coroner's case or a non-criminal matter unless such evidence was discovered, in which event the police would initiate a thorough criminal investigation.

As the OPP observed in its detailed review of the TBPS investigation, in the absence of an ability to affirmatively rule out foul play, a sudden death must be dealt with as a potential homicide and investigated as such. Otherwise, we would add, the police are unlikely to take appropriate steps to determine, as best they can, whether there is evidence of criminality. (If no thorough investigation takes place unless the police already have clear evidence of criminality, less obvious cases of homicide will remain undetected.) This is relevant to TBPS's submission (summarized earlier) that between 2009 and 2016, TBPS has solved 23 of 25 homicide cases. The issue here is not whether TBPS has solved cases involving unquestioned homicides, but whether its

officers have appropriately concluded sudden death investigations where the cause of death or potential criminality is unclear.

The evidence is clear that an evidence-based proper investigation never took place into Mr. DeBungee's sudden death while the original lead investigator led what little investigation took place. The deputy chief's concerns about the adequacy of the investigation up to that point were justified – indeed, he was unaware at that time of the depth of the inadequacy revealed through the OIPRD investigation.

Later, the OPP's independent review of TBPS's investigation, which did not have the benefit of the interviews the OIPRD conducted, nonetheless identified a number of deficiencies in the TBPS's investigation – some of which are also noted in the OIPRD's Investigative Report. In this regard, we also observe that the OPP reviewed the TBPS's investigation after the file had been reassigned, not merely up to the point of reassignment. To state the obvious, those involved in the original investigation, most particularly the lead investigators, played no role in the further investigative work that subsequently took place.

The deficiencies in the investigation included the following:

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

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

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

The deputy chief expressed concern that the original investigators had prematurely concluded that the death was accidental without having conclusive autopsy results and without completing witness statements. He also had concerns about the financial transactions involving the use of the deceased's debit card after his death. Due to his dissatisfaction with the progress of the original investigation, he had the original detectives replaced by others.

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

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

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

The absence of obvious trauma at the scene, and even after the autopsy, did not entitle the investigators to dismiss it as a potential homicide case or treat it as a coroner's case. As a number of witnesses acknowledged, the absence of obvious signs of trauma was not inconsistent with criminal intervention, such as the deceased being pushed into the river.

The real issue should have been whether anything pointed to foul play or suspicious circumstances **after** a proper investigation, not before.

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

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

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

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

needed information from the next of kin and those individuals who were with the deceased the night before he was found.

One of the lead investigators said that investigators made no attempts to interview anyone who was at the residence of the deceased's common-law spouse because the residents told officers that they had left the deceased there with FF. Based on that information, the police determined that they were not the last people to see him.

The second lead investigator said there was no thought of bringing in the people who had been with the deceased for formal interviews as it was determined this was a sudden death, there was no indication that it was suspicious, it was not a major case and there was nothing indicating that it was criminal. If they had anything pointing to it being criminal, they would launch into a criminal investigation. He said that if the CIB officers had been aware that criminal activity was involved, they would have interviewed the individuals who had been drinking with the deceased.

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

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

As indicated earlier, the OPP concluded that there was no basis, at that stage, to determine that the death was non-criminal. A potential homicide should be treated as a serious criminal matter. The media releases undermined confidence in any criminal investigation that followed. This should have been foreseeable by a lead investigator in light of the lack of confidence that Indigenous communities have in TBPS. The media releases also potentially undermined the willingness of witnesses to come forward.

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



One front-line officer took an important statement from KK at the scene. KK described a group of apparently intoxicated Indigenous men and a woman in close proximity to where Mr. DeBungee's body was found the evening before his body was discovered. He also described a physical altercation between two of the men.

Despite the obvious importance of the statement, the officer was uncertain whether he passed this information about KK on to the Criminal Investigations Branch at the scene, though there was no reason why he would not have done so. Based on the available evidence, it cannot be confirmed that the officer conveyed this information to the CIB investigators at the scene. However, he filed a Supplementary Occurrence Report detailing this information on October 19, 2015, at 13:28. It was in the investigative file.

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

In addition to the supplementary occurrence reports contained in the investigative file, uniformed officers spoke to additional individuals at the scene. One officer spoke to NN, OO and QQ at the scene, although he did not personally feel they had relevant information. However, according to him,

OO and QQ purportedly found the health card in FF's name. The OPP report reflected that OO was, in reality, HH There was also some evidence, later developed, that QQ indicated to family members that he had discovered the body. Formal follow-up statements of the witnesses identified at the scene may well have yielded additional information, including any connection between HH and the deceased.

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

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



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

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

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

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

The efforts to find and interview FF were described in the OIPRD Investigative Report. Based on the supervising inspector's advice, FF's name was red-flagged within the service's systems, but other police interactions with him may not have been brought to the attention of the lead investigator. He told OIPRD investigators that they never heard from FF after leaving a message with his father where he was supposed to be staying. They red-flagged him on the police system, and then did nothing about it whatsoever until the issue was raised with the lead investigator by senior management in March, 2016. He said that no other attempts were made to contact FF. He said that despite the fact that there was a warrant for his arrest, the police were more concerned with criminal investigations and do not go looking for people with outstanding warrants. He stated, "That's not my job. I've got other stuff to do." He felt that the case remained a coroner's investigation and he had numerous other incidents he was investigating.

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



On March 24, 2016, the police chief asked the second lead investigator about FF. He told the chief that FF had been on the BOLO (be on the lookout). The chief described this as “a problem,” likely because he had become aware that the police had interacted with FF since his name had been red-flagged. It was obvious that the officer spoken to resented the chief’s intervention.

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

The entire approach to this witness also confirmed one key component of the complainants’ concerns: namely, that despite the lead investigator’s protestation to the contrary, the investigation was not being taken sufficiently seriously. The second lead investigator’s reaction to the police chief’s intervention was also somewhat troubling. The chief was fully justified in raising the issue with him.

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

The investigators’ characterization of this matter also meant that no investigative plan was developed to attempt to address the significant unanswered questions that arose.

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

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

The lead investigators' immediate supervisor was responsible for supervising the investigation into Mr. DeBungee's death. At a minimum, such supervision required that she inform herself about the investigation, provide oversight and guidance where required, and ensure that the investigation was being conducted in a competent way.

There is compelling evidence that her supervision and oversight of the investigation was wholly inadequate. She was either unaware of or indifferent as to the serious deficiencies in the investigation. There appeared to be little or no formal process for assigning a lead investigator in this matter, and very little supervision or oversight of the investigation thereafter. This reflected both a misconception of the nature of the investigation, which should have resulted from this sudden death, and organizational deficiencies.

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

The focus of the OIPRD's conduct investigation was on the investigation that preceded the complaint. However, we also identified some serious concerns about the treatment by TBPS of information pertaining to HH's alleged confession.

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

The senior officer provided a copy of his report to his superior and verbally shared the information he learned from GG with the original lead investigator. An alleged confession relating to Mr. DeBungee's death should have mobilized TBPS to treat this lead on a priority or urgent basis, if it was truly committed to learning the full truth about Mr. DeBungee's death.

However, after Mr. DeBungee's case was re-assigned, the new lead investigator was unaware of GG's statement because it had not even been included in Mr. DeBungee's investigative file. Instead, it had been included in a different investigation file. This cannot simply be attributed to an unfortunate misfiling. Adequate policing required, at the very least, that the new investigators be briefed on this development at the earliest stage of their involvement.

In addition to the above, the OPP found it problematic – and justifiably so – that the police received this initial information about an alleged confession on May 12, 2016, but it was not followed up on until June 30, 2016. This evidence was not treated as an urgent, priority matter, which is troubling given the nature of the information and the complaint already filed against the police.

My Investigative Report also addressed whether the investigation into Mr. DeBungee's death was done in a bias-free manner based on Mr. DeBungee's Indigenous identity. I did find differential treatment, which I will elaborate on in more detail in a later chapter.

## Cases from the Coroner's Inquest into the Deaths of Seven First Nations Youth

Up to this point, I have outlined my analysis and findings in relation to TBPS investigations that were based both on a detailed paper review of the investigative file and other documents, and also on interviews of officers involved in each case. We also conducted additional paper reviews of TBPS investigations. We identified similar issues as those identified in the cases already reviewed. We reviewed the seven cases from the Coroner's Inquest into the Deaths of Seven First Nations Youth. I have recommended four of those for reinvestigation.

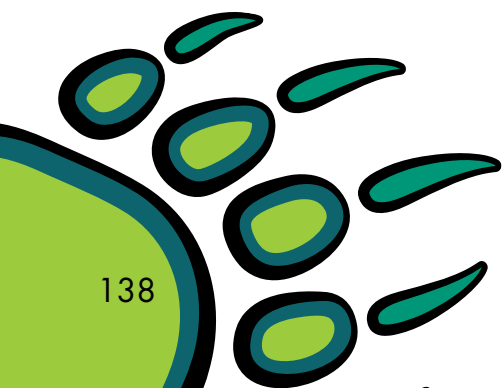
In the cases of M.N. and S.T., the coroner's jury determined the "means of death" was "undetermined." In the cases of O.P. and Q.R., the means of death was determined to be "accident."

## M.N.

M.N. was a 15-year-old Indigenous boy in Thunder Bay as a student of the newly opened Dennis Franklin Cromarty High School. On October 29, 2000, his aunt reported him missing to police. He had not been seen for over 24 hours.

The police reports provided to us did not reveal any police activity prior to November 3, 2000. On that date, a counsellor at Dennis Franklin Cromarty High School advised TBPS that M.N.'s parents were looking for police assistance and that he was assisting them in forming a search party. Two days later, the counsellor advised the detective assigned to the matter that many volunteers were watching various locations M.N. was known to frequent, and that they would be conducting a ground search along the Kaministiquia River behind the Canadian Pacific Station. According to the counsellor, M.N. was known to hang around in that area and consume alcohol. The counsellor expressed the community's concern that M.N. may have fallen into the river, and asked if police could send divers into the river or have it dragged.

The detective indicated that there was no evidence that M.N. had been near the river when he went missing and that senior officers would have to make that decision. The detective committed to making 100 missing person posters for the volunteers. Over the next few days, officers unsuccessfully pursued several leads as to where M.N. might be. This included attending locations in the city where persons had been known to drink



and been assaulted. Several acquaintances questioned whether M.N. was hiding out due to concern that he might be sent back to his First Nation community due to non-attendance at school and consumption of alcohol.

On November 6, 2000, an inspector advised that no foul play was suspected, as it was possible that M.N. was staying with another person or hiding.

On November 8, 2000, an individual advised police that on October 29, 2000, he had found a cap identical to the one worn by M.N. as shown in the missing person poster. He had found the cap at Kaministiquia River Overlook at the eastern end of Kaministiquia River Heritage Park on October 29, 2000, the day after M.N. was last seen. M.N.'s family identified the cap as belonging to M.N.

On November 9, 2000, TBPS officers and Coast Guard staff conducted an underwater search in the area of the Kaministiquia River Overlook, with negative results. The police also received information from a confidential source that alleged that members of M.N.'s family owed money to drug dealers in Thunder Bay, and connected that to why M.N. was missing. There was no evidence in the case files to indicate TBPS followed up on this information.

On November 11, 2000, a witness (B) told police that on October 28, he was with M.N. and others by the water. He said that M.N. was very drunk, kept falling and that one of the girls they were with (C) was beating him because he was with another girl. He last saw M.N. and the other girl near a tugboat when the rest of the group left. Shortly after the group departed, C apparently returned to

the park where M.N. and the other girl had remained. Another group member stated to police that C wanted to beat M.N., but that he did not see any such assault.

The police indicated to the family that a dive team would be assembled to check the area around the tugboat on November 12, 2000. However, later that same day, TBPS were advised that searchers, including an Anishinabek Police Service officer, had located a body in the Kaministiquia River near the Overlook. It was M.N.'s body. Fire/Rescue removed the body from the water. Photographs show that M.N.'s jacket was off. One of his hands was wrapped in the jacket's sleeve.

The coroner was contacted at 5:40 p.m. and attended the scene. The body was removed for autopsy. Later that day, the coroner viewed M.N.'s body, observing that there was bruising to the left cheek as well as an abrasion on M.N.'s forehead. The injuries were photographed.

An autopsy was conducted shortly thereafter. The pathologist concluded that the cause of death was likely drowning although he had "more investigative techniques to use before a final report was submitted." At that time, foul play was not suspected. Two days later, the coroner reported that the cause of death was "asphyxia due to drowning," and that M.N.'s body could be released, although forensic results from some tissue samples taken would take some time for analysis.

A constable reported that on October 29, 2000, he stopped three individuals (C, D and E) near the bowling alley. D was bleeding from an abrasion above her eye and had a two to three inch "blob" of blood on her pants. It also appeared as if her nose had been bleeding. She told the officer that she had fallen.

Witness E told police that on the evening of October 28, 2000, he met up with M.N., C and D at Kaministiquia Overlook Park. Everyone had been drinking. Between 12:30 and 1:30 a.m., M.N. said he was going home and began walking along the dock. The witness stated that he, C and D left a while later, were stopped by the police, and took a cab home.

M.N.'s girlfriend F was located in custody on November 5, 2000. She stated that she last saw M.N. on October 28, 2000, between 7 and 8 p.m. on the riverbank at the foot of Donald Street at the Kaministiquia River Park. Present at that time were five other women she did not know and a man (G). F advised police that she argued with M.N. because he was "making moves" on one of the other girls. As a result, she left the park with G.

A security guard at the bus terminal reported that he had seen M.N. at the bus terminal on November 1, 2 and 3, 2000, and indicated that there would be video for the police to review. TBPS subsequently reviewed the videos with the assistance of members of the M.N.'s First Nation search team. The videos were of poor quality and the results were inconclusive.

On November 11, 2000, TBPS issued a news release regarding M.N.'s death. It stated, "At this point foul play is not suspected, but a post-mortem will be conducted tomorrow morning to try to determine a cause of death."

Another witness (H) was interviewed by Nishnawbe-Aski Police Service on November 11, 2000. She stated that on the evening of October 28, 2000, she was with the group drinking by the river, including M.N. She identified at least five others present, including C and D. H said that she left by herself at some point. The following day, C told her that she had beaten M.N. because he tried to pick her up.

On November 12, 2000, another witness (J) was interviewed. She stated that she too was at the waterfront at about 9 p.m. on October 28, 2000, in the company of M.N., C and D and three other women. According to J, D was assisting M.N. to walk. He was intoxicated and may have fallen. D was angry at him because he tried to hug one of the other women. J stated that she left shortly after 11 p.m., leaving M.N. and C and D behind. M.N. was "fooling around" with D. C had told him to stop. D later told J that M.N. was depressed and felt that he may have jumped into the river.

The police interviewed C on November 12, 2000. This was not a cautioned statement. She maintained that she was under the bridge with M.N. and others on the evening in question. M.N. was intoxicated and fell down several times. A car pulled up. M.N. thought it was the police and ran off towards the tugboat. C admitted that she was angry at M.N. for upsetting D, but denied hitting him and did not know how he ended up in the river.

D was also interviewed on November 12, 2000. This, too, was not a cautioned statement. D said that on the evening in question, she was with M.N. and a number of others, including C and F, earlier described as M.N.'s girlfriend. They were drinking by the waterfront benches close to the tugboat. F was angry that M.N. was with the group. D told police that she liked M.N. and they were hugging and kissing. M.N. was also with another woman for a while. She said that C probably punched M.N., but she did not know. She recalled that C told M.N. that he better not "play her," which she took as a reference to M.N. being with other women that evening.

Another witness (K) reflected that at about 4 a.m. on October 29, 2000, C and D arrived at her home in an intoxicated condition. D's face was covered in blood and C had blood on her hands. C indicated that she had beaten up D and her boyfriend (who she believed to be M.N.). Days later, when this witness learned that M.N. was missing, she asked C and D about it. They denied any knowledge. On November 6, 2000, she spoke to a group assembled in her backyard about M.N. One of the males present stated that if the police became involved he would be in trouble. (The witness told police that he had retained a lawyer in the event that he was questioned by police.) Another stated, "Remember I wasn't there." (The police interviewed that male several days later. He denied being with the others by the water at the material time.) All denied any knowledge of M.N.'s whereabouts.

Subsequently, K became fearful after learning that C and D might belong to a local gang. She came across a piece of paper in C's room with the following written on it: "[D's] boyfriend is still missing. I hope they find him soon. I'm starting to feel really bad about beating him up before he went missing. The Ghetto Blood Sistaz + GBS "z."

There is no indication that any further investigation was done regarding this case until a man (L) in custody contacted the police. He was interviewed on August 11, 2004. He stated that he wanted to get the entire matter off his chest. He implicated C, D and J in M.N.'s death. According to L, M.N. was D's boyfriend and he was caught trying to be intimate with C. The women assaulted M.N. and pushed him in the water, possibly tied up.

L explained that approximately a month and a half after the incident, he began dating C. While at a party, C, D and J were crying and told him what really happened to M.N. It sounded to L as if C engaged in most of the assaultive behaviour. L became afraid for his safety and broke up with C.

Upon receipt of L's statement, police reviewed the existing file. It was discovered that no autopsy report had ever been obtained. The report was subsequently obtained. It reflected that the cause of death was "asphyxia due to drowning." The toxicology report indicated that M.N.'s blood alcohol level was 233mg/100ml.

The police discounted L's statement, despite the existence of other evidence collected during the initial investigation that supported M.N. having been the victim of an assault. No further investigation was documented.



The investigative file indicated that despite the fact that a missing persons report was made on October 29, 2000, TBPS's Criminal Investigations Branch did not become involved in the case until November 4, 2000 – six days later.

In testimony at the coroner's inquest, M.N.'s aunt quoted a police officer saying, "He's just out there partying. He's just out there like any Native kid that drinks all the time." Any such comments, if made, support the criticism of TBPS not taking reports of missing Indigenous people seriously.

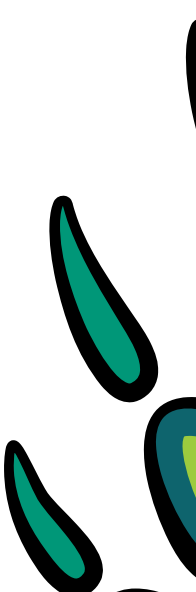
Timely investigations allow for a greater opportunity to obtain evidence and gain access to witnesses. Timely interviews make it more likely that witnesses will have much better memories of events, and are more likely to lead to successful outcomes in missing persons investigations.

Some steps were taken by police to interview some of the individuals who might shed light on M.N.'s death. However, we can only describe the investigation as wholly inadequate. The police received evidence from multiple sources that M.N. had been assaulted prior to his death. Nonetheless, no sustained or serious criminal investigation followed. Some of the individuals mentioned as being part of the group with M.N. just before he went missing were never interviewed. Nor does the file reflect appropriate steps to attempt to do so. No effort was made to potentially collect forensic evidence (for example, clothing from C and D for analysis).

Interviews of C and D and others showed poor investigative techniques. For example, C and D were never confronted with existing statements from others for explanation. It did not appear that consideration was

even given to whether they should be cautioned. Certainly nothing in that regard is documented in the police file. There is no indication that the pathologist was advised of relevant evidence collected during the brief police investigation. The file does not reflect any discussion about the obvious injuries revealed on M.N.'s body or any concerns that should have been prompted by how M.N.'s jacket was wrapped around one of his hands.

It is deeply concerning (and consistent with our findings on other cases) that the absence of an autopsy report in the file was not even noted until a witness came forward years later. As observed in other files, the police failed to understand that the autopsy findings only explained the ultimate cause of death, not how M.N. came to be in the water, and whether it was a result of a criminal act, misadventure or accident. On the totality of the circumstances, it is difficult to understand the basis upon which this death was so readily characterized as non-suspicious. Indeed, the available evidence raises significant concerns about criminality.



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.

The OIPRD conducted a paper review of this file only. However, the file compels the conclusion that M.N.'s death did not get the attention it deserved. It also invites consideration as to whether this is explained by his personal circumstances, Indigenous status or both. At the very least, the poor quality of the investigation had the effect of undervaluing his life.

We do not know how M.N. came to his death. We do know that we cannot safely rely on the investigation that has been conducted to date in determining how he came to his death or in evaluating whether criminal charges are warranted. A reinvestigation is necessary.

## O.P.

O.P. was an 18-year-old Indigenous youth living in a Thunder Bay boarding home while attending Dennis Franklin Cromarty High School. He was reported missing by a Northern Nishnawbe Education Council staff member at 10 p.m. on September 22, 2005. The report mistakenly said he was last seen at 5:30 p.m. on September 23. O.P.'s boarding parent told police that O.P. had been grounded for stealing, but that she had seen him sneak out of the house at approximately 5:30 p.m. on September 22, 2005. He did not return home.

There is no indication of any police activity before September 24, 2005, when a detective indicated that he had received the missing persons report and had been assigned the file. Police checked the Brodie Street Bus Terminal and the Simpson Street area with negative results. The investigative file noted that O.P. had two outstanding warrants for his arrest at the time.

On September 25, 2005, a woman (B) came forward with information pertaining to O.P. She stated that on the evening of September 22, 2005, she and others were with O.P. drinking by the river in the Intercity area near the railroad bridge. They initially had two bottles of vodka among the group. After those bottles were consumed, they returned to the LCBO to acquire a third bottle of vodka and returned to the river. Ultimately O.P. became so intoxicated that he passed out. The rest of the group left him there and went home between 9 and 10 p.m. B speculated that O.P. may have ended up in the river, but

had no information to support that. She also took police to the place where they had been consuming alcohol.

Another witness (C) corroborated B's account, adding that no fighting or disputes took place. He also added that they left their backpacks where O.P. passed out. C returned the following day. The backpacks were still there, as well as O.P.'s hat and shirt, which C took with him.

Another witness (D) corroborated the accounts given by the others. He did not know O.P. prior to that night.

On September 26, 2005, investigators conducted video interviews with the individuals who had been with O.P. at the river prior to his disappearance. Investigators met with O.P.'s parents, the Chief of O.P.'s First Nation, community members who had arrived in Thunder Bay to search for O.P., O.P.'s boarding parents, NNEC staff members and DFC staff members to provide an update on the missing persons case.

Police officers and First Nation searchers conducted a ground search along the banks of the river in the area indicated by the witnesses. This yielded no results. TBPS issued an "all media fax-out" of the missing person poster.

On September 26, 2005, the OPP Underwater Search and Recovery Unit arrived and began searching for O.P. at 6:45 p.m. An hour and 15 minutes later they located and recovered O.P.'s body in the river approximately 15 metres east of the location identified by the witnesses. He was in two to two and a half metres of water, four metres from shore. He was face down, had no shirt or socks on, his pants were undone but up, and he was missing one shoe. Forensic identification officers attended and took photographs. The coroner attended the scene and ordered an autopsy.

The autopsy was conducted in Thunder Bay. The autopsy report was not contained in the investigative file. Nor was the coroner's report. The OIPRD subsequently obtained the autopsy and coroner's report from TBPS. The forensic identification officer reported that the pathologist stated that "because of the hand position it would indicate that O.P. was alive when he went into the water." It is unclear what that hand position was or how it indicated that O.P. was alive when he went into the water. The autopsy report did not reference the hand position. The officer also noted that both shins had "redness associated

with them." The pathologist apparently could not say what could have caused this redness. The autopsy report said nothing about injuries. Although photographs were taken, they were not supplied to the OIPRD. The autopsy report indicated that a pair of red lace panties were found in the back pocket of O.P.'s pants. The officer who attended the post-mortem also mentioned the panties in an occurrence report. O.P.'s lungs were full of water and the cause of his death was "consistent with drowning and acute alcohol intoxication." Toxicology testing showed a blood alcohol level of 285 mg/mL.

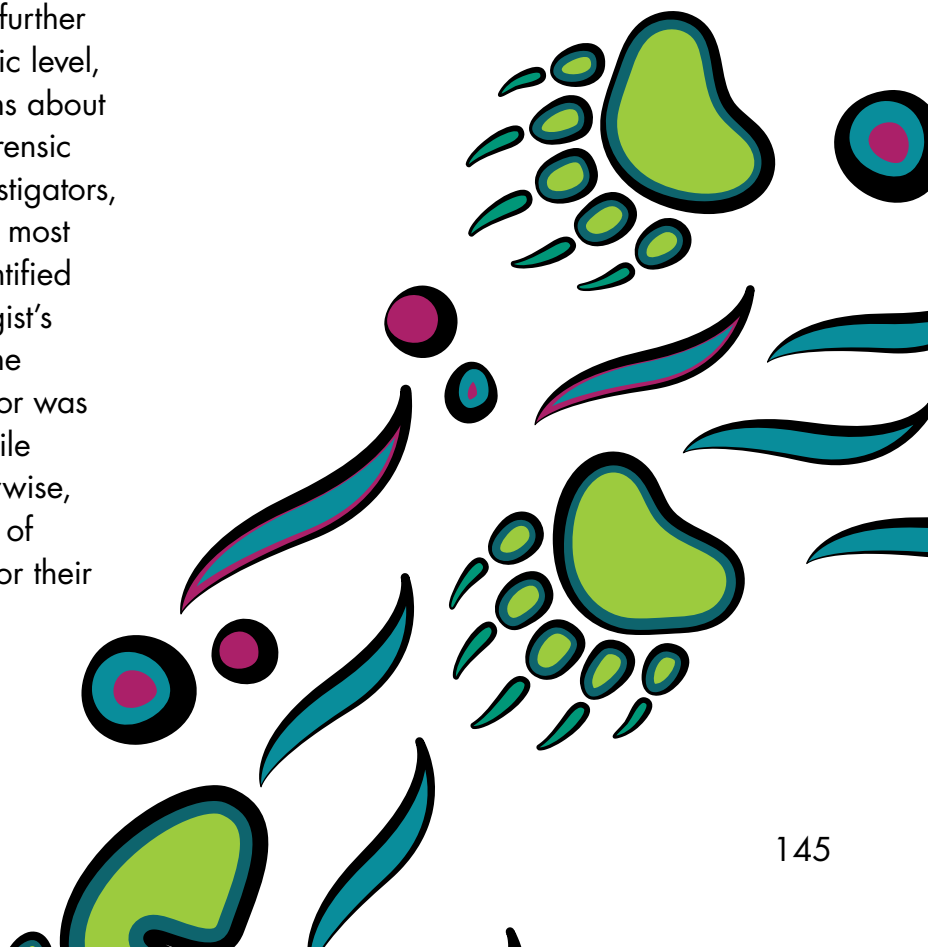
No documents indicate that any further investigation was done on this matter after O.P.'s body was found.

All of the individuals who were consuming alcohol, including O.P., were under the legal age to consume alcohol. It was highly likely that someone purchased the alcohol for the group. There was no investigation into this issue despite O.P.'s high blood alcohol level, and the reasonable conclusion that the act of obtaining alcohol for O.P. likely contributed to his death. All of the individuals drinking with O.P. were interviewed before his body was found. They were not re-interviewed after his body was discovered or after the autopsy was completed.

The red marks on both of O.P.'s shins are suspicious. It would appear that these injuries were not investigated by the pathologist. An intoxicated person passed out beside a river, who dies of drowning with red marks on both shins, is cause for concern. There is little attention given to this finding and no further investigation is indicated. At a systemic level, this investigation again raises concerns about the limited interaction between the forensic identification officer, the criminal investigators, the pathologist and coroner. Even the most rudimentary discussion about the identified injuries, albeit limited, or the pathologist's conclusion that O.P. was alive when he entered the water did not take place or was never documented. The investigative file reflects no follow-up, forensic or otherwise, to determine ownership of the [article of clothing] found in O.P.'s back pocket or their relevance to the investigation.

Unlike some other cases recommended for reinvestigation, the police did not receive any information that invited consideration of foul play by persons unknown or identified. However, I do recommend that this case be reinvestigated as well. TBPS was not in a position, based on the very limited investigation conducted, to rule out foul play in this death. TBPS was obligated to further investigate how these under-aged youth acquired the alcohol which likely contributed to O.P.'s death. The requirements laid out in the Adequacy Standards in Ontario for the investigation of suspicious sudden deaths were not fulfilled here.

In some of these cases, the passage of time may make reinvestigation difficult. The point of recommending reinvestigation is to reflect that in these cases, the original investigations were so incomplete or inadequate to prevent the ruling out of foul play or third party contributions to the deaths.



## Q.R.

Q.R. was a 17-year-old Indigenous youth in Thunder Bay to attend Dennis Franklin Cromarty High School. On October 28, 2009, a school counsellor reported to police that Q.R. had not been seen since 4 p.m. on October 26 at school. The counsellor advised that Q.R. had gone missing before (although this had not been reported), but usually returned the next day. On October 30, 2009, Q.R.'s father arrived in Thunder Bay to search for his son. Police also learned that the money Q.R.'s parents put in an account for him had not been accessed since his disappearance. Police issued a media release that night.

On October 31, 2009, police spoke to an individual (B) who stated that he knew Q.R. well and ran into him on Thursday, October 29, 2009, at approximately 3:30 p.m., under the bridge that crosses the Neebing River near Churchill Street. Q.R. was with a female B did not know. He tried to convince Q.R. to go to school, but he declined. Q.R. and the female continued walking along the river towards James Street.

On November 1, 2009, police spoke to another young person, C. The principal of DFC had previously spoken to C about Q.R.'s disappearance; however, he did not believe what C said. C told police that he last saw (and spoke to) Q.R. on October 26, 2009, in the company of D. C would not reveal the topic of the conversation and was evasive.

Various unconfirmed sightings of Q.R. were reported to the police over the next few days.

On November 10, 2009, TBPS Aboriginal Liaison Unit officers met with two members of NAPS and, by telephone, the Chief and Council of Q.R.'s First Nation to provide an update on the investigation.

On that same date, police interviewed a woman (E) who had provided information to the staff at Shelter House. She told police that she had heard on the street from F (using a street name only) that Q.R. owed a large sum of money for cocaine. F also told her that Q.R. was being held by a male named G (using a street name) in a house on [name deleted] Street. Police records indicated that G was the street name of a resident with a history associated with drugs and violence.

At 3:30 p.m. on November 10, police received a call from a citizen, who saw a body in the river by the train trestle over the McIntyre Floodway. The body was subsequently identified as that of Q.R.

Q.R. was removed from the river. The coroner attended the scene and ordered an autopsy. It was apparent that the body had been in the water for a long period of time. It was noted that there was only one shoe on the body. There appeared to be a superficial abrasion on the left side of the nose and his face appeared swollen.

The scene was photographed and the banks of the river were searched for evidence. None was found. Subsequently, the bottom of the river where the deceased was found was searched for a backpack or sweater. No items were found.

The autopsy report stated that the cause of death was "asphyxiation due to drowning associated with alcohol intoxication." There were abrasions noted on both shins. The photographs of the deceased and the evidence of the forensic identification officer who attended the scene both suggest that the face was swollen, but this is not addressed in the autopsy report. Toxicology results reflected a blood alcohol level of 228 mg/100mL.

Intermittently, between November 11 and 27, 2009, TBPS officers conducted a follow-up investigation in order to determine who Q.R. was with and his whereabouts on the night he disappeared.

Investigation revealed that on the evening of October 26, 2009, Q.R. was drinking with H, J and D, near the area of the river where his body was later discovered (As reflected earlier, C had identified D as someone he saw with Q.R.).

H told police that on October 26, 2009, she and J ran into Q.R. and D at the Intercity Mall. They all agreed to go drinking and went to the trestle bridge over the McIntyre Floodway. She stated that Q.R. became drunk. He started to ask D to get a gun for him for protection, but did not say why he needed protection and from whom. H told Q.R. not to get a gun, which angered him. Q.R. began pushing her and she pushed back, knocking him to the ground. H held him down until he calmed down. Q.R. apologized to her. She and J departed, leaving Q.R. and D there. Q.R. had a backpack with him.

J corroborated H's account, but stated that he had left the others for a while. When he returned, H was on top of Q.R. on the ground and they were arguing, but J did not know about what. They left Q.R. and D at the bridge at approximately 9 p.m.

D stated that he was drinking with Q.R. that evening at the trestle bridge with two women whose last names he did not know. (The first names he attributed to each were different than H and J's names) D claimed that Q.R. left with two females and went to his sister's at approximately 9 p.m. The other statements were not put to him.

On October 26, 2016, senior TBPS officers were alerted to a backpack in police property storage that contained an item of stolen property, [another item] and a K-net<sup>179</sup> print-out of missing person Q.R., with his name, "please call" and a phone number underneath. Detectives were asked to review the Q.R. file. Officers also reviewed the autopsy report and noted the discrepancy between the forensic identification officer's reports and the pathologist regarding swelling and disfigurement on the face.

Further investigation revealed that a youth, (K) was arrested on November 3, 2009, for Weapons Dangerous and Assault Police and this backpack was seized from him. The investigation also revealed that on December 5, 2008, K had been charged with robbing Q.R. and subsequently convicted for that robbery. K died in 2011.

On January 27, 2017, Criminal Investigations Branch officers began looking into a connection between the backpack located in TBPS property storage, K and Q.R. On January 31, 2017, TBPS officers interviewed L, who had been with K when K was arrested on November 3, 2009. Police

asked him about the backpack seized from K and who the backpack may have belonged to. L insisted he didn't know anything about it. He stated he had got out of gangs and wanted to change his life. The police investigation appeared to have ended with this interview.

There were many leads developed during the missing persons investigation which were not followed up on:

- E's tip suggesting that Q.R. was being held against his will for a drug debt was not investigated despite police records identifying a viable suspect.
- The injuries observed on the body by the forensic officer were not reconciled with the lack of notes by the coroner or the pathologist.
- D was clearly deceitful in his interview. C confirmed that D was with Q.R. on October 26, 2009. This was not pursued further. D's story was not investigated.
- There was no mention anywhere regarding the contents of Q.R.'s pockets being checked to determine if he was still in possession of the money card or anything else.
- There was no further investigation of the money card, assuming it was not accounted for.
- There was never a proper description of the backpack or its contents obtained at the time when Q.R. went missing.
- The backpack found in police property storage did not appear to have been sent for forensic examination. Nor was there an investigation conducted to determine whether all the items in the backpack belonged to him or whether they may have led to another party.

Many investigative steps called for in this "suspicious death" investigation were not completed as mandated by Adequacy Standards and best practice. As such, TBPS is not in a position to rule out foul play in this death. Therefore, it should be reinvestigated.



## S.T.

S.T. was a 15-year-old Indigenous youth in Thunder Bay attending Matawa Learning Centre. His boarding parent (a distant cousin) reported him missing on February 8, 2011, at 9 p.m. He left his residence the previous day. Someone (B) told S.T.'s boarding parent that S.T. was seen getting off a bus near his home on February 8 at 10 p.m. in an intoxicated state. This was later corroborated by three witnesses identified through video. However, S.T. never arrived home. S.T. was captured on video from the Intercity Mall on February 7, 2011, at 8:15 p.m. He was alone. Investigation revealed that he had a hockey practice at 8:45 p.m. that same day, but he did not show up.

On February 9, 2011, police issued a missing persons news release. Police also began a grid search in the area where S.T. was last seen, and canvassed door-to-door in that same area and in the area around S.T.'s residence.

On February 12, 2011, missing person posters were created and circulated. Members of S.T.'s First Nation community assisted in the search for S.T. Police also followed up on purported sightings of S.T. in the community.

On February 13, 2011, First Nation members were searching the area of Kingston Road near the river when they observed footprints leading onto the ice near the swing bridge. The footprints ended at open water and there was a hat at that location. The hat was eventually identified as belonging to S.T. through DNA. It was located 2.2 kilometers from where he was last seen.

The OPP Underwater Search and Recovery Unit arrived on February 15, 2011, and conducted searches in the Kaministiquia River around the James Street swing bridges, with negative results. Further ground searches, including an aerial search by helicopter along the river yielded no results.

On February 24, 2011, an individual (C) relayed information that someone (D) had indicated to C's friend (E) that he and others were chasing S.T. to beat him, and that S.T. ran across the river and fell in the ice. D's friend, who was a drug dealer, was apparently also involved. The same day, police informally interviewed D and E who denied any knowledge of this information.

On March 7, 2011, another individual (F) was interviewed. He stated that one week prior he met a male (G) who told F about someone who was a member of the Native Syndicate, an Indigenous street gang, who admitted to G that he had killed S.T., thinking he was someone else with a similar name, XX. He said XX had ripped off the gang in connection with a drug debt.

On March 18, 2011, police received information that XX had fled Thunder Bay, having learned that S.T. was killed in error when XX was the intended target. Police requested that NAPS locate XX to ascertain if he had any information.

On March 21, 2011, Indigenous searchers found a running shoe believed to belong to S.T. near where the hat was found. On March 29, 2011, searchers called police



to an abandoned set of buildings at 1100 Montreal Street, where police discovered what appeared to be dried blood splatters on the inside wall of one building. A folded up jackknife was found in another building and clear industrial plastic wrap was found between two buildings with apparent blood stains on it.

On April 26, 2011, the Centre for Forensic Sciences identified the DNA on the baseball cap found on the ice on February 13 as belonging to S.T.

On May 10, 2011, boaters located a body floating in the water near the western grain terminal. S.T.'s body was removed from the water, wearing the mate to the earlier recovered running shoe. His body was located approximately 650 metres east of where his hat was recovered. The coroner attended the scene and ordered an autopsy. It was conducted in Thunder Bay on May 11, 2011.

Meanwhile, XX was located in Thunder Bay. He acknowledged he did have a previous drug debt, but said it had been cleared and, as a result, he had been back in Thunder Bay for a few weeks. He told officers that he did not know how the rumours about S.T. being mistaken for him began. He would not elaborate or provide details.

A police report dated May 12, 2011, reflected, in part, that the officer who attended the autopsy indicated the pathologist said that S.T.'s cause of death was "cold water drowning," with contributing factors being "alcohol use, cold ambient temperature." The pathologist also noted that there were no other marks or injuries on S.T.'s body to indicate any other trauma before his death. The report further states that "in the absence of any other evidence, there is no reason to suspect foul play." The toxicology report received June 24, 2011, indicated that a low level of oxycodone and traces of cannabis were present in S.T.'s blood, as was alcohol at 158 mg/100mL.

On May 21, 2011, yet another individual (H) came forward, indicating that J told her that two named individuals (K and L) had thrown S.T. off the bridge onto the ice after an altercation. J corroborated this account. K and L subsequently denied any knowledge of the incident described and provided a motive for the false accusation made about them.



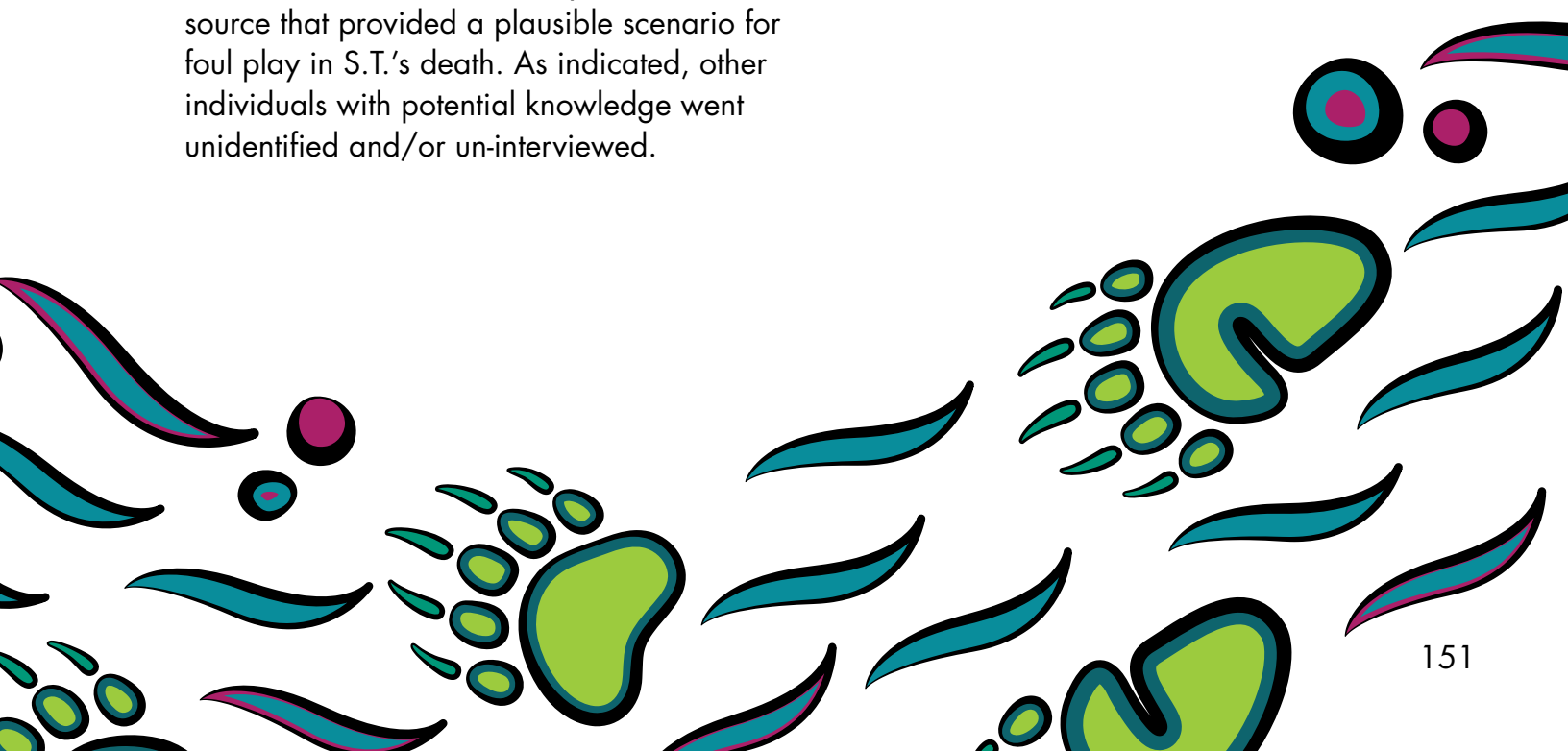
The police interviewed multiple individuals in connection with S.T.'s disappearance and death. However, it is very difficult to understand how the police concluded, even after the autopsy, that "in the absence of any other evidence, there is no reason to suspect foul play." The information that S.T. was mistakenly targeted for drug debts instead of XX was received from more than one source. XX confirmed that he had owed money, and another witness told police that XX was in hiding, out of fear that S.T. had been mistakenly targeted as a result of XX's debts.

There were several leads to follow-up on and individuals to interview who may have had direct knowledge of this matter. This was not pursued. XX was spoken to in the back of a car, and others with potentially critical information were "spoken to" at home. This did not represent sound or adequate investigative action.

The circumstances surrounding the disappearance of S.T. were immediately suspicious as he was last seen by multiple witnesses near his home. Information was received and corroborated by more than one source that provided a plausible scenario for foul play in S.T.'s death. As indicated, other individuals with potential knowledge went unidentified and/or un-interviewed.

There is compelling evidence that S.T. may have been a victim of a crime. In the investigative file, TBPS indicated in February 2011 that foul play was suspected and the case was being treated under the Major Case Management system. However, from the records the OIPRD received, it appeared that the Major Case protocol was only followed between February 12 and February 17, 2011. Based on the materials the OIPRD was provided, several significant pieces of information that came in were not assigned as tasks under the Major Case Management system. When S.T.'s body was recovered on May 10, 2011, and no obvious signs of trauma were identified on the body, the investigation petered out and by June 14, 2011, it had stopped.

Based on Police Adequacy Standards for the Province of Ontario, including the requirements of the Criminal Investigation Management Plan, this investigation was incomplete and should be reinvestigated.



# Death Investigations Involving Indigenous Women and Girls

Throughout the systemic review, I have been acutely aware of the ongoing national crisis of Missing and Murdered Indigenous Women and Girls (MMIWG). Indigenous women in Canada are six times more likely to be victims of homicide than non-Indigenous women.<sup>180</sup> Serious concerns have been raised across Canada about the quality of police investigations concerning these tragic deaths, and the effectiveness of the Canadian justice system in protecting the lives and the dignity of Indigenous women and girls. It is for this reason that my terms of reference require that the review will be “informed by... the ongoing National Inquiry into Missing and Murdered Indigenous Women and Girls.” The National Inquiry’s work has not yet been completed.

As indicated earlier, four of our most detailed review of cases – involving not only a full paper review, but interviews of a number of involved officers involved – related to the deaths of Indigenous women or girls. In addition to those, my team conducted paper reviews of 11 additional files involving the deaths of Indigenous women and girls.

The earliest of these deaths occurred in 1977. The most recent occurred in 2015. Some of the deaths resulted in criminal convictions, while others remain open or unsolved. The documents available for my review varied from case to case. Some files included very limited information, such as the coroner’s report or a synopsis, while other files were voluminous.

We found similar failings in some of these cases to those observed in our broader review of TBPS sudden death investigations. In particular, we found similar failures to preserve the scene, properly interview witnesses, and follow investigative leads. Some of these flawed investigations appeared to culminate in premature findings of accidental death that are similar to the cases that we have recommended for reinvestigation. Notably, four of the nine cases we have recommended for reinvestigation involve Indigenous women.

It was beyond the scope of my mandate to address the measures undoubtedly needed to protect Indigenous women and girls from widespread violence. It is obvious that urgent action is required, and that hopefully, the National Inquiry will document the extent of the crisis nationwide and how it should be responded to. However, the solution must include robust, effective, bias-free and timely investigations into the disappearances and deaths of Indigenous women and girls. TBPS has often failed to deliver effective and non-discriminatory death investigations in relation to Indigenous people, including Indigenous women. Although my recommendations can only address the situation in Thunder Bay, they may provide guidance more generally on how such investigations can and must be improved.



During the course of the systemic review, two Indigenous youths were found dead in Thunder Bay waterways. Tragically, both died on the same weekend in May 2017. The Chief Coroner for Ontario asked York Regional Police to assist TBPS in investigating these two deaths. I expanded my review to encompass these two cases. We reviewed the YRP investigative reports only. We did not receive these case files from TBPS.

## **Tammy Keeash**

Tammy was a 17-year-old Indigenous youth living in Thunder Bay. She and three friends went to Chapples Park where they drank alcohol. Tammy became intoxicated and passed out. Her friends turned her onto her side. Eventually they left the park, leaving Tammy behind. The next day Tammy's body was found face down in the Neebing-McIntyre Floodway, which runs through the western part of Chapples Park.

The water in the floodway where Tammy was found was about 14 inches deep and covered in tall reeds and grass. The autopsy report stated the cause of death was "drowning in a girl with acute ethanol intoxication." York Regional Police interviewed witnesses and found no evidence to support any foul play in her death. They determined it was possible that Tammy fell down the embankment and came to rest in the location where she was ultimately found. The YRP report stated that the temperature went below freezing overnight and it was likely that Tammy succumbed to hypothermia and drowned where her body was recovered.

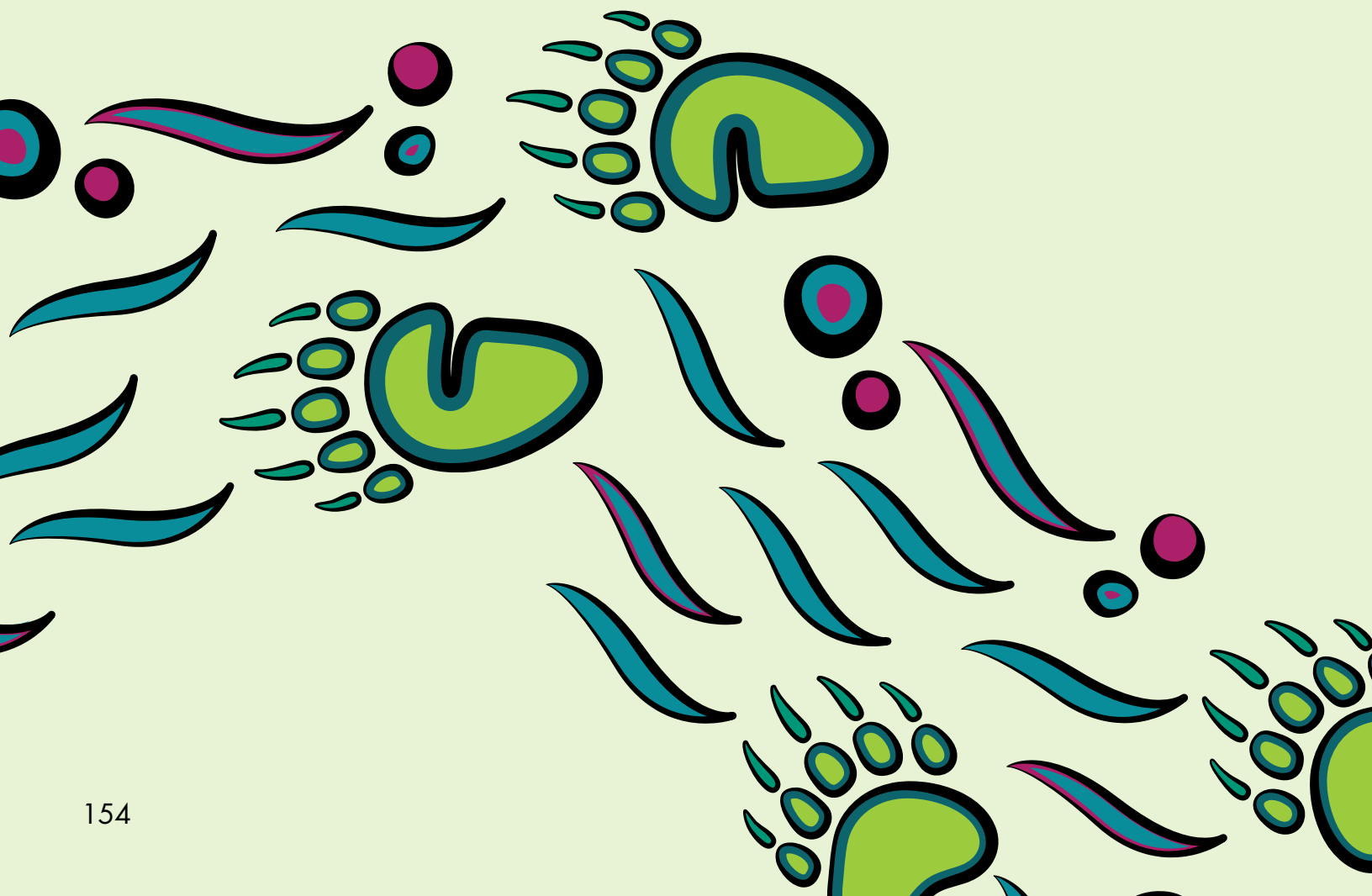
## **Josiah Begg**

Josiah was a 14-year-old Indigenous youth, who was visiting Thunder Bay with his father for a medical appointment. He met up with another youth and they went to a location near the Balmoral Street Bridge by the McIntyre River to consume alcohol. Josiah was reported missing two days later. TBPS launched a missing persons investigation, focusing on a ground search that proved to be unproductive. On May 18, 2017, 12 days after he was last seen, OPP divers recovered Josiah's body from the river.

The Thunder Bay coroner's office initiated a death investigation with TBPS assisting with the investigation. In June 2017, the Chief Coroner for Ontario asked York Regional Police to assist TBPS with its investigation. YRP's investigation focused on interviewing witnesses. After a number of interviews with witnesses, YRP concluded its investigation. YRP investigators were unable to determine how Josiah Begg drowned, but believed that the other youth who was with Josiah may have had culpability. However, they were not able to confirm this belief. YRP also indicated that the possibility remained that an unknown third person was involved in the incident, or that Josiah fell in the water on his own.

The OIPRD reviewed the investigative reports from YRP, and also met with the Chief Coroner and the senior YRP investigator regarding these two investigations. The YRP officer identified systemic issues in how TBPS conducted both investigations, including the under-resourcing of TBPS's General Investigations Unit, as well as training issues. YRP investigators observed that inexperienced TBPS investigators were sometimes mentoring and training new investigators. More generally, YRP noted the limited levels of experience some TBPS had in conducting major investigations assigned to them.

YRP's involvement in these files allowed TBPS officers to familiarize themselves with best practices associated with death investigations for which officers expressed their gratitude.



# CHAPTER 8: FINDINGS AND RECOMMENDATIONS FOR TBPS INVESTIGATIONS AND OPERATIONS



# Findings: TBPS Sudden Death And Other Investigations

In the previous chapter, I outlined in detail the deficiencies I found in some of the cases we examined. These deficiencies were not confined to these cases. Our review of multiple case files confirmed the existence of numerous issues that were systemic in nature.

**The inadequacy of Thunder Bay Police Service sudden death investigations that 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 TBPS investigators involved in these investigations lacked the expertise and experience to conduct sudden death or homicide investigations.**

We saw frequent examples of officers who did not know what they did not know. These officers were thrust into a lead investigator role within the General Investigations Unit without adequate skills or training to perform that role.

**Investigators frequently misunderstood when matters should be investigated under the Major Case Management system.**

Investigators repeatedly failed to recognize what constitutes a potentially suspicious death and that a sudden death must be investigated as a potentially suspicious

death unless or until the evidence supports the contrary. Investigators presumed, in a number of sudden death cases, that the death was attributable to accidental or natural causes, unless there was obvious evidence to the contrary.

This misguided approach meant, in a number of sudden death cases, investigators did not embark on any meaningful investigation because there were no obvious or unequivocal signs of foul play. It also explained, in part, why officers came to premature conclusions about individual cases.

**Investigators regularly failed to connect the autopsy report to their own investigations. On multiple occasions investigators failed to even find out the autopsy results, or failed to understand the significance or lack of significance of the autopsy findings. Very often, investigators did not attend autopsies held outside of Thunder Bay. There are logistical issues associated with lead investigators attending autopsies in Toronto. However, that does not relieve TBPS from its obligation that the officer or officers who do attend (and should attend under Major Case Management protocols) are familiar with the case and share relevant information with investigators.**

**On a number of occasions, attending forensic identification officers did not fulfill basic requirements. It is also unacceptable for lead investigators not to attend the autopsy because they have prematurely drawn conclusions about the cause and circumstances surrounding a sudden death.**

For example, officers concluded that death by drowning meant that the death was innocently caused, rather than investigating how the deceased came to be in the water. Similarly, death by hypothermia was interpreted to mean that the death was innocently caused, rather than investigating whether a third party was responsible for rendering the deceased incapacitated or unconscious.

In many instances, the investigators failed to provide the pathologist performing the autopsy with sufficient information to ensure that the autopsy findings were complete and relevant. For example, the disconnect between the investigation and the autopsy findings manifested itself in a pathologist inferring that injuries might be attributable to resuscitation efforts, when no investigation was done to determine whether such efforts had even taken place.

Because a number of cases were not investigated under the Major Case Management system, as they should have been, the autopsy reports were not in the investigative file – even where the investigation purportedly remained “open.”

An integral part of a proper death investigation involves the forensic identification officer working together with the investigator and the pathologist/coroner in a coordinated way to ensure every death is explained and investigated thoroughly. Generally, TBPS investigators did not attend autopsies held outside of Thunder Bay. Forensic Identification Unit officers who did attend were often unfamiliar with key evidence uncovered, rarely discussed the case adequately with the investigators or were not the forensic officers involved in the actual investigation.

### **Local coroners, as well as investigators, failed to understand the role of the coroner or did not share a common understanding of that role.**

Investigators delegated their responsibility to the coroner, or deferred to the coroners in sudden death investigations when the coroner lacked any expertise to decide – nor was it their role to decide – whether the death should be treated as suspicious. This manifested itself in the following ways:

- Coroners sometimes reported to the chief coroner that TBPS investigations were often less thorough than those they observed of other services.
- In some cases, coroners indicated to investigators they did not need to attend the autopsy.
- At the scene, FIU officers took direction from coroners and insufficient direction from their own investigators.

Meaningful case conferencing involving the pathologist, investigators and the coroner did not take place in cases that warranted it. Indeed, coordinating investigator-pathologist case teleconferences remotely has proven difficult for TBPS.

More generally, the absence of quick and easy access for investigators to a forensic pathologist outside Thunder Bay has had a negative impact on the quality and timeliness of TBPS death investigations.



**Investigators exhibited poor interviewing techniques in a number of sudden death and homicide cases that were reviewed.**

This was manifested by:

- Failures to conduct meaningful interviews with key witnesses. There was often little or no cross-referencing to what other witnesses had to say
- Failures to ask fundamental questions or asking leading questions when open-ended inquiries were called for
- Decisions to interview key witnesses while they were together rather than separately
- Failures to conduct formal interviews when required
- Failures to accurately or completely record what the witnesses said

**Investigators' poor interviewing techniques were compounded by repeated failures to interview key witnesses at all, and failures to regularly monitor the availability of witnesses not yet interviewed.**

**There were repeated failures to understand the legal rights of witnesses or suspects. This, of course, had the potential of undermining the admissibility of evidence in court proceedings.**

**Investigators failed to know what was in their own investigative file, including supplementary occurrence reports filed by uniform patrol officers.**

**There was very poor supervision and oversight of sudden death and homicide cases.**

Existing supervision failed to uncover basic shortcomings in investigations. Until recently there was no regular review process in place.

**TBPS staff told us the collection of information needs to be better coordinated and relevant information filed to ensure such information is brought to the attention of the lead investigator. Staff accurately described issues associated with TBPS's file management system.**

For example, we found it difficult to find several files because of inappropriate labelling. These files were not identified by the name of the deceased, but by locations where deceased were found, like "Marina" or "Field." Police staff explained that locations may be used to identify a file when the deceased's name is not immediately known to investigators. We were advised that the system does not permit subsequent changes to the file name.

Major Case Management and other systems in place in this province permit the description of the deceased person as "unknown." They also permit the substitution of the deceased's name when known. It is a best practice for maintaining the personal dignity of the deceased and for file-tracking that the file be described by name or as "unknown."

**The General Investigations Unit in the Criminal Investigations Branch is under-resourced.**

Under-resourcing of this branch significantly hinders the quality, adequacy and timeliness of investigations, particularly in sudden death or homicide cases. The point is addressed in more detail later in this report.

All of these systemic issues were shared with the Acting Chief of Police (now the Chief of Police) and the head of the Criminal Investigations Branch during the course of the systemic review investigation. It was my view that the issues were too significant to await completion of this report. TBPS advised me of steps taken to address a number of these issues, including revising its Sudden Death Policy and implementing a Sudden Death Review Committee. These are described elsewhere in this report.

# RECOMMENDATIONS ON TBPS SUDDEN DEATH AND OTHER INVESTIGATIONS

**1. Nine of the TBPS sudden death investigations that the OIPRD reviewed are so problematic I recommend these cases be reinvestigated.**

- Based on the lack of quality in the original investigations of the following deaths. I cannot be confident in their adequacy or categorization of outcome:

A.B.	M.N.
C.D.	O.P.
E.F.	Q.R.
G.H.	S.T.
I.J.	

**2. A multi-discipline investigation team should be established to undertake, at a minimum, the reinvestigation of the deaths of the nine Indigenous people identified.**

This team should include representation from TBPS (excluding investigators who originally worked on the cases), a representative from a First Nations Police Service, an experienced investigator or investigators from an outside police service or outside police services, a designated representative of the Chief Coroner's Office and a designated representative of the Chief Forensic Pathologist's Office. The team could also include, as needed, a Crown counsel from another jurisdiction.



Before any such reinvestigation begins, the multi-discipline investigative team should liaise with affected families and ensure support mechanisms are in place for those families. In choosing a support mechanism, the team should consider restorative processes similar to the Family Information Liaison Unit (FILU) service that the Ontario Ministry of the Attorney General's Indigenous Justice Division (IJD) provides to families of MMIWG.

Ontario established the Family Information Liaison Unit (FILU), in partnership with Justice Canada, to support families of MMIWG to access information related to the loss of their loved ones. Ontario's FILU is part of the Indigenous Justice Division and began providing services to families of MMIWG in March 2017.

The FILU has four field offices located in Sudbury, Thunder Bay, Sioux Lookout and Toronto. FILU staff are members of Indigenous communities who have years of experience working with Indigenous women and girls. They bring a deep understanding of the historical context of violence against Indigenous women and girls and the unique needs of families who have suffered the loss of a loved one.

Ontario's FILU facilitates Family Circles, which most often involve affected family members, the investigating police service, the Office of the Chief Coroner, and, where appropriate, Crown attorneys. The Circles provide a trauma-informed, culturally relevant and safe space for families to discuss their experiences. Families are given an opportunity to ask questions to understand the circumstances surrounding the loss of their loved ones. They often include an

Elder or other supports upon the families' request. Families receive information from the investigative police service and/or the Office of the Chief Coroner, which can assist them to move forward in their healing process and, in some instances, can provide closure. There is also a significant opportunity to establish trust between officials and families of MMIWG.

**3. The multi-discipline investigative team should establish a protocol for determining whether other TBPS sudden death investigations should be reinvestigated.**

It is unrealistic to recommend that all TBPS investigations of Indigenous or other sudden deaths should be reinvestigated. Nor will every sudden death investigation necessarily raise issues that invite reinvestigation. On the other hand, I recognize that we only examined a subset of these cases and that the selection of those cases was partially driven by random sampling. It follows that other deeply flawed investigations may exist and, indeed, are likely. The multi-discipline investigative team will be better situated to evaluate what ongoing protocol should govern other reinvestigations and what evidence should trigger other reinvestigations.



4. The multi-discipline investigation team should also assess whether the death of Stacy DeBungee should be reinvestigated, based on my Investigative Report and the OPP review of the TBPS investigation. The team should also assess when and how the investigation should take place, without prejudicing ongoing Police Services Act proceedings.
5. TBPS should initiate an external peer-review process for at least three years following the release of this report.

This recommendation contemplates that every year, several sudden death and homicide investigations, selected either on a random basis or based on particular complexity, are peer-reviewed by experienced investigators from an outside police service. This is designed to provide further support and expertise to TBPS investigators, ensure heightened competence in accordance with provincial standards and build public confidence. Depending, in part, on the results of this peer-review process, TBPS leadership must determine and publicly report on whether further changes must be made to its investigative processes. As well, if circumstances warrant, TBPS should consider contracting out some of its investigations to the Ontario Provincial Police or analogous police services.

## FINDINGS: TBPS INVESTIGATORS AND THE CRIMINAL INVESTIGATIONS BRANCH

### Officer Resources and Workload

According to Statistics Canada's 2017 Police Resources in Canada report, Thunder Bay had a police strength rate of 197 officers per 100,000 population. This was the fourth highest rate of police strength among stand-alone municipal police services in Canada, after Victoria, Montreal and Halifax.<sup>181</sup>

TBPS has 227 officers including four cadets-in-training working in the following branches: Executive Services, Court Services, Corporate Services, Uniform Patrol, Community Services and Criminal Investigations. The majority of officers work in the Uniform Patrol Branch (129). Criminal Investigations Branch has 51 officers; however, the General Investigations Unit within that branch consists of only 12 officers.<sup>182</sup>

According to TBPS, in 2016, the service responded to 47,907 calls for service with 18,946 of them being reportable, meaning the officer who attended was required to create a written record of the event. That is an average of just over 50 per day. In 2016, TBPS responded to 1,817 crimes of violence, eight of those being homicides. The service also dealt with 158 sudden deaths and 852 missing persons reports.<sup>183</sup>



Many officers who have worked in Criminal Investigations Branch's General Investigations Unit commented on the large caseload they carried and the difficulty in being responsible for their caseload and managing other duties expected of them.

Officers spoke about working very long hours. For example, they reported that an officer might have to go out in the very early morning to bring witnesses to court to ensure they get there, spend the morning in court assisting the Crown, then go back to work on multiple concurrent cases well into the evening. They compared the human resources available internally to conduct sudden death and homicide investigations to the resources available to York Regional Police when its officers reviewed only two of TBPS's sudden death investigations.

**My review of sudden death cases identified the level of staffing in the Criminal Investigations Branch's General Investigations Unit as a major issue that must be urgently addressed.**

TBPS's Forensic Identification Unit (FIU), is another team in the Criminal Investigations Branch. It is housed in the Ontario Provincial Police forensic facility on James Street, not at the Balmoral Street headquarters. Some FIU officers describe themselves as the often "forgotten unit," and spoke of the lack of information they were given generally, and when attending scenes.

As indicated earlier, we heard that the FIU officer who attended the autopsy was often not the same officer who attended the initial scene.

## Major Crime Unit

Many police services have a Major Crime Unit. The role of a Major Crime Unit differs between police services. In some services, the Major Crime Unit investigates a range of serious matters or matters of complexity. Larger police services often have further specialized units such as Homicide, Sexual Assault, Fraud or Missing Persons.

Regardless of how these units are configured, it is fundamental to successful investigative work that serious cases are investigated by those who have the training to do so. It is equally fundamental that the investigation of serious or complex cases be led by experienced investigators with organized and effective mentoring of secondary investigators. As reflected earlier, many serious cases should also be investigated in conformity with Ontario Major Case Management standards, as contemplated by the Police Services Act and the Ontario Major Case Management Manual.

TBPS's Criminal Investigations Branch does not have a Major Crime Unit. The few General Investigations Unit investigators work on the widest range of cases that come to the Criminal Investigations Branch for investigation, often regardless of subject matter, seriousness or complexity. Investigators and other staff report that new additions to the General Investigations Unit may immediately become lead investigators in homicides or sudden deaths without adequate training or appropriate skill sets. Investigators conduct sudden death or homicide investigations without necessarily having even taken the homicide course through the Ontario Police College. They conduct serious sexual assault cases without

having even taken the sexual assault course. They, and forensic identification officers, work on cases that should be investigated pursuant to Major Case Management protocols without even having taken a Major Case Management course. Officers repeatedly told us that they want to obtain such training, but systemic issues (such as the limited availability of spots for training, the difficulty in making time for training at the Ontario Police College and strained financial resources) impede their ability to do so. Senior management acknowledged these systemic issues – many attributed to budgetary restrictions.

**It is unacceptable that a police service such as TBPS investigating a large number of serious, complex cases has no Major Crime Unit and that investigators lead the investigation of such cases without appropriate training or experience.**

## **Supervision, Promotion and Mentorship**

**Inadequate supervision resulted in many shortcomings identified in the investigative files we reviewed.**

Officers candidly told us they had concerns about the adequacy of supervision. During my systemic review, TBPS created a sudden death review committee to provide oversight on sudden death investigations. Senior management reports that the committee and more robust direct supervision have resulted in timely identification of additional measures to be taken in individual investigations. The creation of more formalized supervision is, of course, both commendable and necessary. It is too early to evaluate whether existing

supervision will adequately address the full range of deficiencies identified in my report.

**Inadequate training and mentoring of officers leading or participating in investigations of serious cases also contributed to many shortcomings identified in the investigative files we reviewed.**

Incentives for advancement within the police service means investigators may be promoted out of the Criminal Investigations Branch. Experienced investigators are not easily replaced. I also recognize that some investigators become fatigued and less effective over time, requiring that they be rotated out of investigative duties. It is a challenge for any police service to appropriately balance these considerations with the desire to build on the expertise and experience of its investigators.

**I found too many examples of officers rotated out of Criminal Investigations Branch at a time when they were near or at the peak of their investigative abilities. Officers accurately described the “constant shuffling” as a problem within the service.**

Some TBPS officers indicated that if promotion and transfer to Criminal Investigations Branch were linked too closely to experience, inexperienced officers with high potential would be unable to obtain these positions. Of course, this legitimate concern is significantly reduced if new investigators are appropriately mentored and do not initially lead the investigations of serious or complex matters.

**The mentoring within TBPS has often been unproductive due to the uneven skill levels of even the more experienced investigators and varying abilities to mentor effectively.**

## **Information Sharing with other Police Services**

**Information sharing between TBPS and other police services continues to be uneven and unsatisfactory and can result in policing “silos.”**

TBPS does not integrate its Niche system with other services, a concern identified by some of the officers interviewed. This contributes to a lack of information sharing and lack of full coordination with other police services such as NAPS, APS and the OPP.

TBPS employees told us that getting information from another service often requires written requests, is time-consuming and wastes valuable officer time. Part of the problem rests with the failure of TBPS to integrate its Niche system with other police services. There is no valid reason for routine requests for information to be unnecessarily burdened by a lack of integration of Niche systems. This not only adds to the investigative burden of officers, but contributes to a lack of information sharing and lack of full coordination with other police services such as NAPS, APS and the OPP.

NAPS and APS officers described TBPS as “an island” or as “isolated.” TBPS officers also described the silos that exist between the police services, although a number of TBPS officers reported good one-on-one relationships with APS and NAPS officers.

TBPS sometimes enlists NAPS’s assistance in speaking with witnesses or addressing other needs pertaining to its investigations, particularly in remote First Nation communities. NAPS also makes its aircraft available to TBPS officers.

NAPS police chief Terry Armstrong (since retired), confirmed his service’s willingness to work with TBPS on issues of shared concern. He also confirmed that some tensions exist between the services, including the palpable level of mistrust shown by some TBPS officers towards NAPS.

Several TBPS officers reported concerns about the confidentiality of information shared with NAPS. As a result, they were reluctant to share investigative information freely. Their concerns were said to be related to NAPS’ oversight model, which some TBPS officers feel involves greater oversight by the political leadership of NAPS’s operational activities.

**I find totally unconvincing and unsupported by the evidence available to me that the suggestion that NAPS’ oversight model or the involvement of political leadership prevent information sharing and robust cooperation between these police services.**



# RECOMMENDATIONS ON TBPS INVESTIGATORS AND THE CRIMINAL INVESTIGATIONS BRANCH

**6. TBPS should immediately ensure sufficient staffing in its General Investigations Unit in the Criminal Investigations Branch. Adequate resources must be made available to enable this recommendation to be implemented on an urgent basis.**

- Staffing of this unit must be informed by the number and range of cases undertaken by this unit in the past five years.

**7. TBPS should establish a Major Crimes Unit – within the Criminal Investigations Branch – that complies with provincial standards and best practices in how it investigates serious cases, including homicides, sudden deaths and complex cases.**

- This unit should be led by a respected and seasoned investigator who meets the criteria for Major Crime investigators, and has a proven track record of conducting investigations according to provincial standards.
- Active supervision of the Major Crime Unit should include reviews of investigative reports, approval or review of investigative plans at the outset of an investigation, regular updates as required, and the random review of audio/video statements to ensure that interviewing best practices are being followed.
- Serious consideration should also be given to whether the Major Crimes Unit's supervisor should be recruited from another police service.
- A Major Crimes Unit should be staffed by investigators who have:
  - Received accredited training in sexual assault, homicide and Major Case Management
  - Received Indigenous cultural competency training
  - Within one year of the release of this report, received specialized training on the deficiencies identified by my review of individual cases investigated by TBPS
  - The specialized training should be accompanied by the development of clear police board policies and police service procedures that are compatible with the Criminal Investigation Management Plan and Adequacy Standards for Police in Ontario.





8. **TBPS should provide officers, who have taken the appropriate training with opportunities to be assigned to work with the Criminal Investigations Branch and the Major Crimes Unit investigators to gain experience.**
  - This would also help supervisors evaluate their potential as investigators.
9. **TBPS should develop a formalized plan or protocol for training and mentoring officers assigned to Criminal Investigations Branch and the Major Crimes Unit.**
10. **TBPS should develop a strategic human resources succession plan to ensure the General Investigations Unit, the Criminal Investigations Branch and the Major Crime Unit is never without officers who are experienced in investigations.**
11. **TBPS should establish procedures to ensure occurrence or supplementary reports relevant to an investigation are brought to the attention of the lead investigator or case manager. This must take place regardless of whether a case has been earmarked for Major Case Management.**
12. **TBPS should develop procedures to ensure forensic identification officers are provided with the information necessary to do their work effectively.**
  - These procedures should include, at a minimum:
    - Clarity around the lead investigators' role in informing Forensic Identification Unit (FIU) officers about existing information, and taking an active role in directing FIU officers as to their scene responsibilities. FIU officers need information from investigators about what may be important at a scene in relation to the investigation. Of course, this should not be a "one-way street." FIU expertise should also inform investigative decision-making.
    - Steps to ensure that, absent truly exigent circumstances, FIU officers who attend an autopsy are the same officers who attend the initial scene. Alternatively, FIU officers should be fully briefed about the case before attending an autopsy.
    - Steps to ensure that FIU officers fully brief the lead investigators about the findings at an autopsy.
13. **TBPS should immediately improve how it employs, structures and integrates its investigation file management system, Major Case Management system and its Niche database.**
14. **TBPS should, on a priority basis, establish protocols with other police services in the region, including Nishnawbe-Aski Police Service and Anishinabek Police Service to enhance information-sharing.**

# FINDINGS: OTHER TBPS OPERATIONAL AREAS

## The Aboriginal Liaison Unit

TBPS has had an Aboriginal Liaison Unit (ALU) for more 20 years. The unit consists of two officers who work to develop and maintain positive relationships between TBPS and Indigenous people.

Although ALU officers may sometimes be called upon by investigators to assist, they are generally not involved in investigative work or support. Sometimes they liaise with Indigenous families during investigations. They also visit remote First Nation communities to engage with young people considering going to school in Thunder Bay. TBPS's organizational change project is currently involved in revamping the structure and function of the Aboriginal Liaison Unit.

**There is strong support in the community for the Aboriginal Liaison Unit; however, almost everyone we spoke to told us two officers were insufficient. Many considered it tokenism.**

# RECOMMENDATIONS ON OTHER TBPS OPERATIONAL AREAS

15. **TBPS should fully integrate the Aboriginal Liaison Unit's role into additional areas of the police service. This would help to promote respectful relationships between TBPS and the Indigenous people it serves.**
  - This means, among other things:
    - Greater engagement in facilitating investigations
    - Greater engagement in front-line interactions with Indigenous people
    - Greater ongoing engagement with Indigenous students (i.e., not just school appearances, but availability in crisis and after conventional daytime hours)
    - Greater participation in visits to remote communities
    - Greater visibility within the service and participation in training
  
16. **TBPS should increase the number of officers in the Aboriginal Liaison Unit by at least three additional officers.**
  - Two officers, however competent and well-motivated, represent an inadequate number of officers to perform the ALU's functions, both currently and as recommended in this report.



**17. With Indigenous engagement and advice, TBPS should take measures to acknowledge Indigenous culture inside headquarters or immediately outside it.**

Indigenous people interact with TBPS in many different contexts. TBPS headquarters presents an unwelcoming physical environment with virtually no representations of Indigenous culture inside or outside the building. I raised this point with TBPS senior management on several occasions. As reflected earlier in this report, TBPS has taken initial steps to implement such a recommendation, though not yet realized.

**18. TBPS should make wearing name tags on the front of their uniforms mandatory for all officers in the service.**

About half of Ontario's police services, including the OPP, require officers to wear name identification. Name tags not only ensure police officers are held accountable for their actions, they also contribute to humanizing police officers and to raising confidence in police.

**19. TBPS should implement the use of in-car cameras and body-worn cameras.**

Police in-car cameras and body-worn cameras have tremendous potential to enhance public safety, contribute to officer training, reduce public complaints, prevent negative interaction between police and members of the public and significantly increase public trust and confidence in police and policing.

In our meetings with members of the public, we heard a disturbing number of reports from people who indicated that while transported in police cruisers, they were subjected to repeated stops and starts – where the driver would accelerate and brake the car rapidly and repeatedly. Some members of the public reported coming away from these incidents bruised and bleeding.

Police in-car and body-worn cameras provide an important and impartial record of events that can protect citizens as well as officers. They not only protect citizens from potential abuses of police power but also shield officers from unfounded complaints about their conduct. Moreover, these cameras are beneficial from a training perspective as the recordings can be used to review interactions and learn from them.

When implementing in-car camera and body-worn camera use, specific policies and procedures should be developed regarding all aspects of the use of such technology. Direction should be provided to officers to inform them how and when to advise members of the public they are being recorded. Guidelines for training and disclosure must also be developed and publicized.

TBPS has very recently undertaken a body-worn camera pilot project, which is commendable.

**20. TBPS should, through policy, impose and reinforce a positive duty on all officer to disclose potential evidence of police misconduct.**

TBPS officers, including senior officers, should take responsibility for ensuring that the policies, obligations and requirements of good policing are met. Senior officers should not condone or distance themselves from the misdeeds or misconduct of subordinates and colleagues. Condoning inappropriate or illegal behaviour brings great disrespect to the service and to policing. It also erodes public confidence in police.



## FINDINGS AND RECOMMENDATIONS: MISSING PERSONS CASES

Some of TBPS sudden death cases the OIPRD reviewed began as reported missing persons. Steps were taken by police and/or community members to search for these individuals.

TBPS told us that Thunder Bay has one of the highest rates of missing persons in Canada. These are the statistics provided to us for the period 2009 to 2016.

Most of these missing persons are young people; many are Indigenous.

### TBPS Missing Persons

Age	2009	2010	2011	2012	2013	2014	2015	2016	Total
Under 12	80	73	78	52	45	57	48	29	462
Over 12	1,510	1,597	1,526	934	673	775	957	823	8,795
Total	1,590	1,670	1,604	986	718	832	1,005	852	9,257

Fortunately, many of these people are located safely. Nevertheless, the disappearance of people, regardless of duration, is of obvious concern. The Coroner's Inquest into the Deaths of Seven First Nations Youths addressed the timeliness of missing persons reports and follow up investigations.

**TBPS has identified steps recently taken to coordinate reporting of missing students, particularly those attending school in Thunder Bay from remote Indigenous communities.**

- TBPS has attempted to streamline communication between schools and TBPS.
- TBPS has told us it is reviewing, on an ongoing basis, its missing persons policies, procedures, officer training, and taking steps to increase public awareness of those policies and procedures.

# RECOMMENDATIONS ON MISSING PERSONS CASES

## 21. I urge the Ontario government to bring into force Schedule 7, the Missing Persons Act, 2018, as soon as possible.

Any discussion about missing persons policies and procedures would be incomplete without a reference to the Safer Ontario Act, 2018 – Bill 175. This legislation, which was passed in 2018, introduced a variety of measures dealing with policing. It has not yet come into force. Schedule 7 of the bill, the Missing Persons Act, 2018, recognizes, in its preamble, the seriousness of the issue of missing persons in Ontario and its negative impact on the family and loved ones of missing persons. The act is designed to enhance the tools available to police when attempting to locate missing persons. The preamble also states:

The Government of Ontario recognizes that the circumstances surrounding each missing person's absence are unique, but that sexism, racism, transphobia, homophobia, other forms of marginalization and the legacy of colonization are factors that may increase the risk of a person becoming a missing person.

The Government of Ontario acknowledges the importance of timely and effective measures being available to police to assist with locating missing persons. These measures must also take into account people's privacy interests and agency.

The act provides a definition for when a person constitutes a missing person for the purposes of the act, and introduces enhanced measures that police may employ to assist in locating a missing person in the absence of a criminal investigation. These include orders for the production of records and search warrants to facilitate the search for a missing person.

For example, a justice of the peace may issue an order for the production of certain types of records based on shown evidence that there are reasonable grounds to believe that the records are in the custody or under the control of an identified person and will assist in locating a missing person. The justice shall not issue such an order unless he or she is of the opinion that the public interest in locating the missing person outweighs any privacy interest associated with the records.

The justice shall also consider any information suggesting that the missing person may not wish to be located, including information that suggests that the missing person has left or is attempting to leave a violent or abusive situation. An officer may also make an urgent demand for such records if reasonable grounds exist that the missing person may be seriously harmed or the records may be destroyed in the time required to obtain a judicial order. Police may also obtain a warrant authorizing entry into premises based on sworn evidence that there are reasonable grounds to believe that the missing person may be located at the premises and entry is necessary to ensure that person's safety.

The act also clarifies what information may be disclosed publicly by the police to assist in locating a missing person. The act requires police to annually report on measures taken pursuant to the act, and contemplates that the act's provisions will be reviewed within five years.

In my view, this legislation strikes an appropriate balance between the need for timely and effective measures to assist in locating missing persons and privacy concerns.

**22. TBPS and the Thunder Bay Police Services Board should re-evaluate their missing persons policies, procedures and practices upon review of the report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, due to be released on or before April 30, 2019.**

This report may provide significant insights for TBPS on how it should conduct missing persons investigations pertaining to Indigenous women and girls. This report should also inform TBPS's ongoing review of its policies, procedures and practices.

**23. TBPS and the Thunder Bay Police Services Board should re-evaluate their missing persons policies, procedures and practices upon review of the Honourable Gloria Epstein's report on the Toronto Police Service missing persons investigations due to be released in April 2020.**

Recently, the Toronto Police Services Board created an independent civilian review of missing persons investigations conducted

by Toronto Police Service. As I understand it, the review is designed to evaluate how Toronto Police Service investigated eight missing persons later found dead, as well as how the Service conducts missing persons investigations more generally. Its terms of reference place emphasis on the search for missing persons from vulnerable or marginalized communities. The report of this review is due to be delivered by April 2020.

This report may well provide significant insight for TBPS on how its own missing persons investigations might be enhanced, particularly in relation to Indigenous young people.

## **FINDINGS AND RECOMMENDATIONS FOR THE RELATIONSHIP BETWEEN THE POLICE AND THE CORONER'S OFFICE**

Coroners are practicing physicians appointed by the Province on the recommendation of the Chief Coroner. Coroners investigate deaths that may occur under circumstances as defined in the Coroners Act – for example, sudden deaths or deaths that occur in correctional institutions. In these cases, coroners must determine the identity of the deceased and the facts as to how, when, where and by what means the deceased came to his or

her death. Coroners may hold inquests into the deaths where it would be in the public interest to do so.

Pathologists are specialized medical doctors who have five additional years of training after medical school in pathology and the study of disease. Forensic pathologists also have post-graduate training in forensic pathology and the application of medicine and science to legal issues, usually in the context of sudden death.<sup>184</sup>

Although Ontario coroners are medical doctors, coroners cannot perform autopsies, since they are typically not qualified as pathologists. Pathologists or forensic pathologists perform autopsies. Coroners can issue a warrant and direct a pathologist to perform a post-mortem examination (also known as an autopsy) of a body that they have taken possession of in accordance with the Coroners Act. Some pathologists are also coroners.

**There are serious issues with the relationship between the police and the coroners, including lack of coordination, delegation and information sharing.**

During my review it became obvious these issues could not await the completion of this report before being drawn to the attention of the Chief Coroner for Ontario and TBPS's senior management. The Chief Coroner was already aware of a number of these issues.

We worked together with the Chief Coroner to enable him to address some of these issues on a priority basis, resulting in a new framework to address the shortcomings identified by the Office of the Chief Coroner,

in consultation with Ontario's Chief Forensic Pathologist and the Regional Coroner, as well as TBPS.

**I support the development and use of the framework created by the Office of the Chief Coroner. The framework takes into account many of the issues and underlying concerns identified by my report.**

## **RECOMMENDATIONS FOR THE RELATIONSHIP BETWEEN THE POLICE AND THE CORONER'S OFFICE**

- 24. The Office of the Chief Coroner, Ontario's Chief Forensic Pathologist, the Regional Coroner and TBPS should implement the Thunder Bay Death Investigations Framework on a priority basis, and should evaluate and modify it as required, with the input of the parties, annually.**
- 25. The Office of the Chief Coroner should ensure police officers and coroners are trained on the framework to promote its effective implementation.**
- 26. The Office of the Chief Coroner and TBPS should publicly report on the ongoing implementation of the framework in a way that does not prejudice ongoing investigations or prosecutions.**

The framework is reproduced below:

## **Intersection of Police and Coroners for Thunder Bay Death Investigations**

The purpose of this framework is to identify challenges that have occurred during investigations of sudden deaths and provide steps to bring about future improvement. Our goal is to ensure objective high quality death investigations for everyone.

Police services and coroners have clearly defined areas of jurisdiction and authority. Coroners and police work together as a team when investigating sudden deaths, acting within their mandates to perform a thorough, appropriate job in understanding the circumstances of the death. Knowledge and understanding of the other's role and authority is critical to a quality investigation. It is why clear and consistent communications is so important – without it, there is a risk that each may rely on the other inappropriately and to the detriment of the investigation. The circumstances of each case inform who leads the investigation. Where there are obvious criminal concerns, the coroner will defer to the authority of the police; and when the case is undifferentiated and criminal concerns may or may not be present, the police will assist the coroner in gaining the answers required while continuing to pursue necessary investigative steps to ensure potential criminality is satisfactorily evaluated.

## **Scenarios Requiring Special Attention / Higher Index of Suspicion**

- Deceased person in a non-secure location (including unidentified individuals)
- Marginalized population (including Indigenous and other racialized individuals, homeless)
- Young deceased persons, women and vulnerable elderly
- Death with an “obvious” cause, i.e., drowning, that requires investigation to evaluate the circumstances leading to that cause

### **Challenges include:**

- Premature conclusions or case closure, or ending the investigation before full understanding of the circumstances of the death has been determined including affirmatively ruling out foul play/criminality
- Over-reliance on the absence of traumatic injuries identified at the post-mortem examination may incorrectly provide reassurance and reduce the focus on other concerning features
- Premature release of a scene with potential loss of evidence based upon preliminary opinion provided by a coroner



- Issues with the amount and quality of information shared between those involved in the case, i.e., coroners, police investigators and forensic pathologists
- Preliminary communication with media or family providing premature and potentially inaccurate opinion or findings
- Delay in appropriate notification of family members

## Strategies to Address / Mitigate

- **Investigative Authority Clarity**
  - Absence of traumatic injuries does not eliminate potential criminal concerns
  - The coroner takes possession of the body of the deceased person
  - Police continue to play a key investigative role in cases with and without criminal concerns
  - Police determine whether a crime has been committed and affirmatively determine that foul play was not involved
  - Police will follow investigative protocols to the extent necessary to evaluate for any potential criminal concerns
  - Police will take suitable investigative steps, using standard investigative techniques, to ensure the circumstances of the death are understood to the extent required by the coroner
- **Enhanced Communication** in high profile cases types and all cases referred to the Provincial Forensic Pathology Unit (PFPU)
  - The attending coroner should directly communicate with the lead police investigator at scene with ongoing communication during the course of the investigation.
  - Definitive determination regarding absence of traumatic injuries should not occur until completion of the post-mortem examination.
  - The investigating coroner shall notify the Regional Supervising Coroner about deaths outlined above including where there are initial potential criminal concerns.
  - The Regional Supervising Coroner will send out a High Profile Case notification.
  - Discussion should occur between the investigating coroner and the lead detective about the potential benefit of holding the scene.
    - This should occur in undifferentiated cases
    - If there are no specific criminal concerns, the coroner will provide the authority to hold the scene where required and the police will provide the service
    - If criminal concerns, the police will hold the scene under their investigative authority and continue to inform the coroner of their findings

- Continuity of the body should be maintained by use of body pouch and forensic evidence seal.
  - Consideration should be made for accommodation of post-death cultural practices
  - Accommodation considerations should be discussed with the Regional Supervising Coroner and Ontario Forensic Pathology Service
- Coroners shall speak directly with pathologist (ideally before the autopsy) and ALWAYS after the autopsy has been completed.
- When there are potential criminal concerns or one of the above noted death scenarios are present, the lead detective must share the available investigative information and the scene findings (supported by sharing and review of photographs) with the examining pathologist before the post-mortem examination.
  - If desired this may be completed remotely when the post-mortem examinations are referred to the Provincial Forensic Pathology Unit
  - The autopsy coordinator will assist with arrangements for transmission of photos and teleconference meetings
- The police service will determine the need for attendance of an identification officer at the post-mortem examination – there may be opportunity for the police service to arrange a coverage process with OPP or Toronto Police Service for cases referred to the PFFU.
- After completion of the post-mortem examination the pathologist will communicate directly with the investigating police detective and the coroner.
- The Regional Supervising Coroner will act as a resource throughout the investigation and will arrange at minimum one case conference, though more complex cases may require interval case conference throughout the investigation prior to case closure.
- Decisions about information sharing with the family will be guided by presence or absence of criminal concerns.
  - When criminal concerns are present the coroner will work with the family liaison from the police service to facilitate communication – this is to ensure that information is not released that may impact the integrity of the criminal investigation

- When criminal concerns are not present the coroner shall make every reasonable effort, with the assistance of police, to communicate with the family:
  - Prior to the completion of a post-mortem examination to ensure opportunity for family to express potential objections or accommodation requests
  - After completion of the post-mortem examination by sharing the preliminary findings of the examination and investigation as well as providing guidance about next steps
  - As often as indicated, but certainly prior to case closure, to ensure the family are aware of information as it is obtained during the investigation.
- Information should not be released to the media in non-criminal death investigation apart from confirming investigation of the death if asked
- Family should know the names and contact information for the lead police investigator, the investigating coroner, and the Regional Supervising Coroner
- Families must be advised how they can access additional information and reports

## FINDINGS AND RECOMMENDATIONS FOR THE RELATIONSHIP BETWEEN THE POLICE AND PATHOLOGIST

We spoke with the Chief Forensic Pathologist of the Ontario Forensic Pathology Service (OFPS) regarding our review of death investigations in Thunder Bay. The OFPS believes that it must provide high quality regionalized death investigation service delivery in northern Ontario and that it is important for the OFPS to provide medico-legal autopsy services that are compatible with cultural and societal norms in First Nation communities.

**There are significant challenges affecting the ultimate quality and timeliness of TBPS investigations, in not having a Forensic Pathology Unit in Thunder Bay and in the requirement that TBPS officers must be sent to Toronto for autopsies.**

These challenges were identified by FIU officers, TBPS investigators and senior management and the Chief Forensic Pathologist.

# RECOMMENDATIONS ON THE RELATIONSHIP BETWEEN THE POLICE AND PATHOLOGIST

- 27. The Ontario Forensic Pathology Service should train all pathologists on the Intersection of Police and Coroners for Thunder Bay Death Investigations as set out in the framework.**
- 28. TBPS should reflect, in its procedures and training, fundamental principles to define the relationship between investigators and pathologists.**
  - These should include:
    - TBPS should ensure the pathologist conducting any autopsy is fully aware of all relevant circumstances regarding the death. The onus is on the lead investigator(s) to ensure this is done and a record made of the information shared with the pathologist. That record may be made by an FIU officer attending the autopsy.
    - TBPS should ensure that the autopsy findings (whether conveyed orally, in writing or both) have been accurately recorded and communicated to the lead investigator(s) and preserved in the investigative file in a timely way.
- TBPS should ensure all relevant coroner's reports and pathologist's reports, including the final post-mortem examination or autopsy report and any ancillary reports (such as toxicology reports) are placed in the investigative files for sudden death or homicide cases in a timely way.
- TBPS should develop a procedure to ensure that lead investigator(s) review the reports.
- 29. The Ontario Forensic Pathology Service should establish a Forensic Pathology Unit in Thunder Bay, ideally housed alongside the Regional Coroner's Office.**
- 30. If a Forensic Pathology Unit cannot be located in Thunder Bay, TBPS and the Ontario Forensic Pathology Service should establish, on a priority basis, procedures to ensure timely and accurate exchange of information on sudden death and homicide investigations and regular case-conferencing on such cases.**
- 31. The Ontario Forensic Pathology Service should provide autopsy services compatible with cultural norms in Indigenous communities.**
  - This is an important first step to ensure that OFPS is responsive to the needs of Indigenous people and of TBPS in carrying out investigations involving Indigenous people. I support the Chief Forensic Pathologist's decision to recruit, train and hire Dr. Kona Williams to serve as a liaison between the OFPS and Indigenous communities.

# CHAPTER 9: FINDINGS AND RECOMMENDATIONS REGARDING RACISM



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

The views and experiences described by community members and organizations along with TBPS officers and TBPSB contributed to my findings on racism, as well as the perception of racism, within TBPS. 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 TBPS, 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 TBPS. There is a widespread perception that TBPS 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, TBPS, to date, has not been successful in earning the confidence of Indigenous communities.

## Racism, Stereotyping and Racial Discrimination

Moving from the perception of racism to racism itself, I now address issues surrounding racism within TBPS 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.**

## The Hidden Nature of Racial Prejudice

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."<sup>185</sup>

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."<sup>186</sup>

The Ontario Human Rights Tribunal recently acknowledged the enduring power of these harmful stereotypes to influence police decision-making.<sup>187</sup>

## Guiding Principles for Analyzing Racial Discrimination

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.

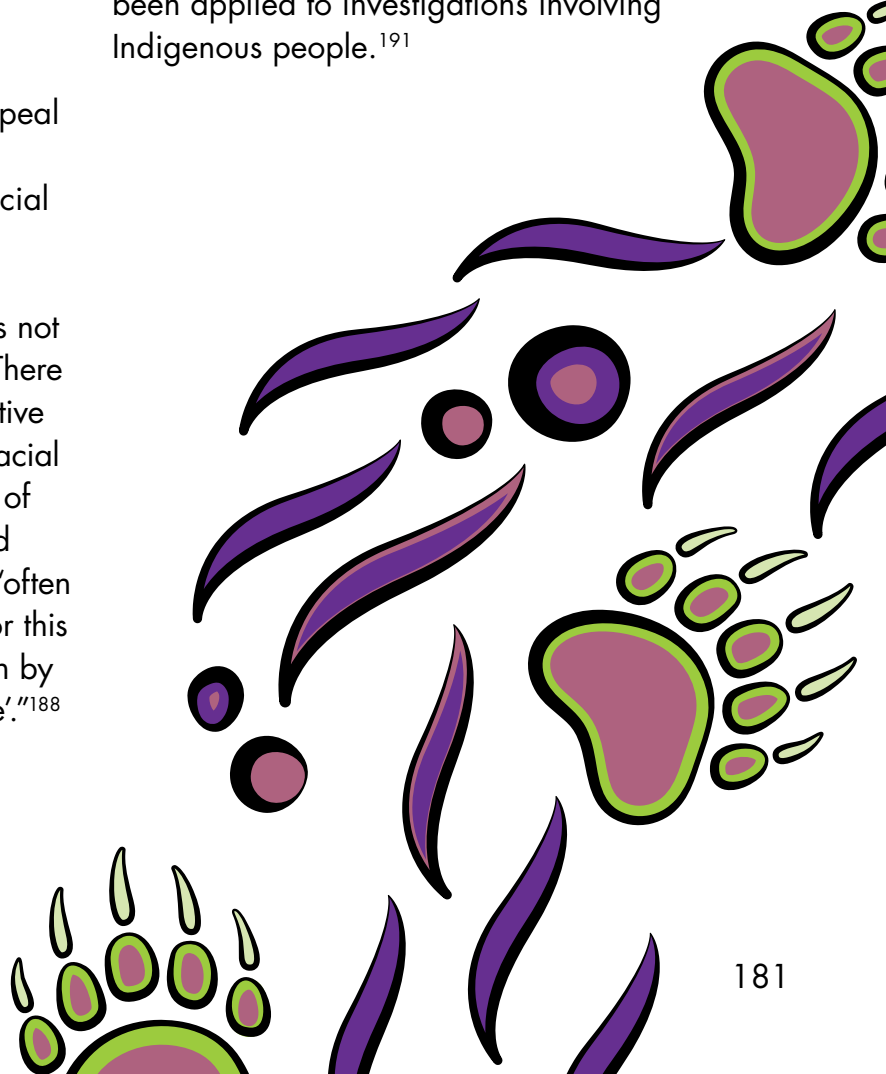
The courts have acknowledged that in this day and age, blatant forms of inter-personal discrimination are rather exceptional, and that subjective intent to treat someone unequally is not required to prove racial discrimination. Rather than searching for direct evidence of overtly racist statements or 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.’”<sup>188</sup>

Under the Ontario Human Rights Code, a tribunal hearing a complaint of racial discrimination first considers whether there is a “*prima facie* case” of discrimination. Three elements must be satisfied for a *prima facie* 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.<sup>189</sup>

Once a *prima facie* case is established, the onus shifts to the respondent to provide a “rational explanation” for the conduct that is not discriminatory.<sup>190</sup> This framework has been applied to investigations involving Indigenous people.<sup>191</sup>





# ARE TBPS DEATH INVESTIGATIONS AFFECTED BY RACIAL DISCRIMINATION?

Our detailed review of cases involving sudden deaths of Indigenous men and women found that TBPS 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.

Our case reviews showed investigators:

- Too readily presumed accident in cases of Indigenous sudden deaths
- Relied upon evidence of drowning as if it virtually determined that the death was accidental
- Relied upon evidence of hypothermia as if it virtually determined that the death was accidental
- Placed extraordinary weight on the deceased's level of intoxication as if it virtually determined that the death was accidental
- Failed to take even the most basic investigative steps in a number of sudden death cases
- Ignored evidence potentially pointing to a non-accidental cause or contribution to death

TBPS 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.

As I reflected in my Investigative Report, the Stacy DeBungee case is a compelling example of this.

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

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

On the available evidence pertaining to this investigation, we accept that Officer A and others believed that they do not engage in differential treatment based on race. It is also accepted that Officer A's attendance at the scene to assist the deceased's family in identifying where the deceased was found, was well-intentioned, despite the family's suspicions around his attendance at the scene.

However, the evidence overwhelming supports the inference that Officer A and Officer B prematurely concluded that Mr. DeBungee rolled into the river and drowned without any external intervention. It can also be reasonably inferred that this premature conclusion may have been drawn because the deceased was Indigenous.

A civilian witness, an experienced investigator, felt that the police had "tunnel vision" in relation to the investigation. At the Inquiry into Proceedings involving Guy Paul Morin, the Commissioner defined tunnel vision as "...a single-minded and overly narrow focus on a particular investigative or prosecutorial theory, so

as to unreasonably colour the evaluation of information received and one's conduct in response to that information." In the civilian witness's view, TBPS investigators acted as though they had another intoxicated Indigenous person who fell asleep at the river and that the only probability was that he rolled into the river and drowned. His view finds support in the evidence available to us.

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

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

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

**My finding that investigations were affected by racial discrimination does not represent a determination that all TBPS 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 TBPS 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.

One aspect of systemic racism that we have observed is that TBPS did not have adequate measures in place to ensure supervision and quality control of the investigations we reviewed to prevent racial prejudice from affecting them.

A number of community members suggested that we compare how TBPS investigates sudden deaths of Indigenous individuals and similar deaths of non-Indigenous individuals. There were insufficient comparatives to permit that analysis to be done in any meaningful way. Nor was it ultimately necessary given my ability to make clear findings pertaining to Indigenous sudden deaths.

**Attitudes about Indigenous People among TBPS Officers**

The power that police officers have, and the critical role that a police service plays in promoting racial equality and reconciliation with Indigenous people require that they be held to a higher standard. The impact of racist views within a police organization is more significant than for almost any other institution.

We conducted 35 interviews with TBPS officers in the course of my review. Not surprisingly, we encountered a range of beliefs and attitudes, from the frontline to the executive suite.

Unfortunately, we also heard very disturbing views expressed by some officers in our interviews. While these views were expressed by a minority of officers, they were expressed by more than "a few bad apples." These officers exhibited a contempt bordering on hostility toward Indigenous people, manifesting in an attitude of "blame the victim":

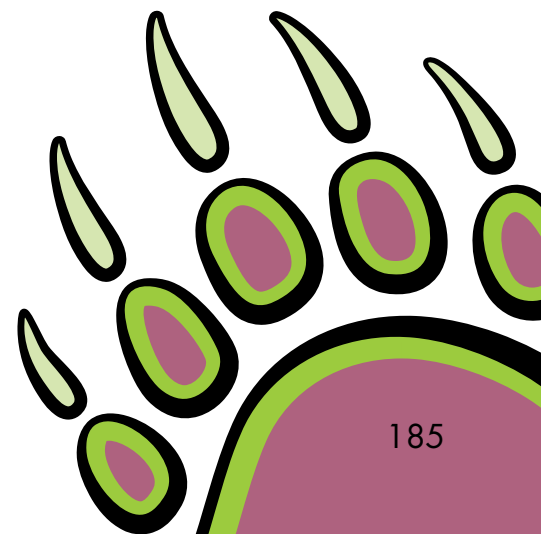
“What would I like to see? I’d like to see the federal government abolish all of the reserves and, not a forceful thing, but an option: “We’re gonna give you each a quarter of a million dollars and you can do with it what you want but from here on in, everybody’s the same and we’re gonna move forward on it... I understand education and I’m a proponent of education. And it honestly pisses me off when I go to areas of Thunder Bay – Limbrick is one area – and I see little kids hanging out of trees like monkeys. And I push my School Resource Officer and my ALU guy in particular because these kids that are there are predominantly Aboriginal and, you know, go there, shake the trees. Shake up the parents and get these kids to school. Because the only way that they’re gonna become better, productive people in society, to be able to speak out for themselves, and to accomplish something other than being on welfare and continuing that cycle is to go and get an education.”

“One of the questions in my mind is if you’re on a reserve and there are no schools and no resources and you want to send your 13-year-old to school, why would you entrust them to a stranger? Why wouldn’t you move yourself? Another good example, if you have to go to Thunder Bay for medical treatment and you decide to take your 13-year-old son with you, why wouldn’t you arrange for someone to supervise your son? Why would that be a police fault when they’re found dead? Why would we be racist towards you or your son when they’re found dead and you didn’t—and you failed to provide? And why is none of that public?”

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:

“Every time we deal with them, it’s – you’re only dealing with me because I’m Native and, not to mention that they’re pissed drunk, they’re pissing up against a building, they’re defecating [by] buildings, they’re fornicating on the riverbank and on people’s cars. There’s businesses that are leaving our Thunder Centre, where family go and do their shopping and stuff like that, but will not go there because of them fighting, drunk, their aggressive panhandling and I mean aggressive, and people just don’t want to deal with it. Yet, when we as the police go because we get called there all the time, we get called racists. They’ll pass out – I’ve seen them right in front of my car passed out cold on the street. Right in front of my car. It’s a wonder that more of them aren’t hit by cars okay? This is what you deal with almost on a daily basis when you live here. You are dealing with that steady? That’s why when people come up and say that it’s suspicious – not really.”

And in one case, we heard an officer admit to being biased.



“And as far as this systemic racism, I personally don’t believe that I am racist. Do we have racist police officers within our police service? Perhaps we do. Am I biased? Absolutely. I would stand up in court, put my hand on the Bible and swear that I’m biased because I don’t know how you could do this job for 33 years and three days and see the same thing over and over and over and not be biased.”

We met many officers who were dedicated to their jobs and well-motivated to serve Indigenous communities. Others lacked an awareness of how colonialism and systemic discrimination contributed to the circumstances of Indigenous people they interacted with while conducting their work.

## RECOMMENDATIONS ON RACISM IN TBPS POLICING – GENERAL

**32. TBPS should focus proactively on actions to eliminate systemic racism, including removing systemic barriers and the root causes of racial inequities in the service. TBPS should undertake a human rights organizational change strategy and action plan as recommended by the Ontario Human Rights Commission in October 2016.**

**33. TBPS leadership should publicly and formally acknowledge that racism exists at all levels within the police service and it will not tolerate racist views or actions. TBPS leadership should engage with Indigenous communities on the forum for and content of these acknowledgements. This would be an important step in TBPS advancing reconciliation with Indigenous people.**

TBPS will not overcome the crisis of confidence for Indigenous people until the service does so. It diminishes the ability to constructively repair the damage of racism to:

- Describe the issue as reflecting the existence of a “few bad apples”
- Focus on blaming Indigenous leadership for the crisis in confidence
- Attribute the legitimate concerns about racism within the police service solely or largely to “political correctness”

**34. The Thunder Bay Police Services Board should publicly and formally acknowledge racism exists within TBPS and take a leadership role in repairing the relationship between TBPS and Indigenous communities. This too, is an important step in TBPS advancing reconciliation with Indigenous people**

Senator Sinclair will report on the board’s role in addressing any systemic issues he has identified. I do not intend to pre-empt his work. However, I have several observations regarding the board.

The board has supported some important initiatives in an attempt to address TBPS's relationship (and the relationship of the board itself) with Indigenous people. However, in my view, the board has, to date, failed to adequately acknowledge the depth of legitimate concerns about how TBPS interacts with Indigenous people, and at times, has too readily minimized or failed to recognize the shortcomings of its police service.

Two illustrations suffice.

First, my review has revealed, at a systemic level, serious deficiencies in how sudden death and homicide investigations have been conducted by TBPS. Although the board is precluded from directing the police on day-to-day operational matters, it also bears the responsibility of ensuring adequate and effective policing in the community. It is obvious that the board has failed to provide the oversight required to fulfill its statutory mandate.

Second, the City of Thunder Bay extended its Walk-A-Mile Indigenous cultural competency training to TBPS officers. This program represented an important first step in educating officers about Indigenous people, and was well-received by a number of the officers who participated in the program. On the other hand, it was reported in the media that, at one session in particular, officers were dismissive of the program or disrespectful towards the trainer.

Different perspectives exist on whether these media reports accurately captured what transpired at the session. But what followed these reports were explanations (not entirely consistent) from TBPS as to why the reports

were unfounded. The board took up the TBPS position publicly without any true probing or introspection about whether there was validity to what had been reported. Its approach contributed to, rather than constructively addressed, the adversarial dialogue around this issue, and exacerbated the negative perceptions that arose. A constructive dialogue around the issue would have presented an opportunity to build bridges, rather than promote tensions. But that did not take place.

**35. TBPS leadership should create a permanent advisory group involving the police chief and Indigenous leadership with a defined mandate, regular meetings and a mechanism for crisis-driven meetings to address racism within TBPS and other issues.**

The OIPRD facilitated the creation of such a dialogue during my review. The issues were too pressing to await my report. It is incumbent on the police chief to sustain this dialogue.

## **RECOMMENDATIONS ON RACISM IN TBPS POLICING – TRAINING**

There was wide consensus during our meetings with policing and community stakeholders that police officers should receive mandatory training designed to promote cultural competency and anti-racism, particularly in relation to Indigenous people, and reduce the likelihood that officers will perform their duties in discriminatory ways.

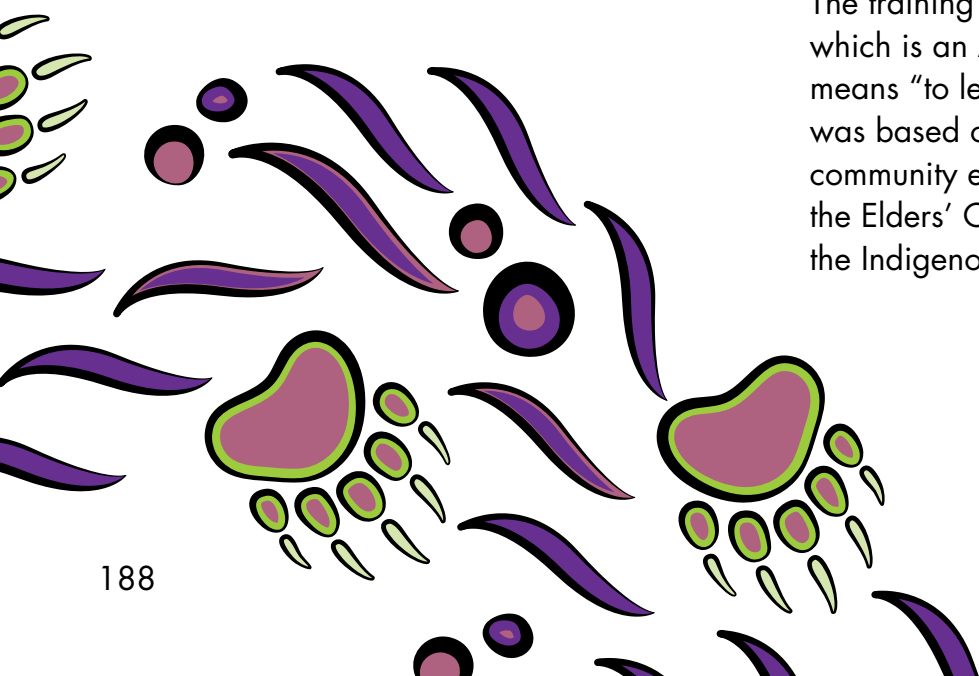
**36. TBPS should work with training experts, Indigenous leaders, Elders and the Ontario Ministry of the Attorney General's Indigenous Justice Division to design and implement mandatory Indigenous cultural competency and anti-racism training for all TBPS officers and employees, that:**

- a. Is ongoing throughout the career of a TBPS officer or employee.
- b. Involves "experiential training" that includes Indigenous Elders and community members who can share their perspective and answer questions based on their own lived experiences based in community.
- c. Is informed by content determined at the local level, and informed by all best practices.
- d. Is interactive and allows for respectful dialogue involving all participants.
- e. Reflects the diversity within Indigenous communities, rather than focusing on one culture to the exclusion of others.

- f. Explains how the diversity of Indigenous people and pre and post contact history is relevant to the ongoing work of TBPS officers and employees. For example, Indigenous culture and practices are highly relevant to how officers should serve Indigenous people, conduct missing persons investigations, build trust, accommodate practices associated with the deaths of loved ones and avoid micro-aggressions. Micro-aggressions are daily verbal or non-verbal slights, snubs, or insults that communicate, often inadvertently, derogatory or negative messages to members of vulnerable or marginalized communities.

In response to The Honourable Frank Iacobucci's 2013 report on *First Nations Representation on Ontario Juries* and the 2015 *Final Report of the Truth and Reconciliation Commission of Canada*, the Indigenous Justice Division (IJD) within the Ontario Ministry of the Attorney General became responsible for the development of Indigenous cultural competency training for justice-sector workers.

The training developed is called Bimickaway, which is an Anishinabemowin word that means "to leave footprints." Its curriculum was based on extensive Indigenous community engagement and guidance from the Elders' Council that guides the work of the Indigenous Justice Division.



It consists of five three-hour core training modules:

1. Pre-contact history; challenges the participants to consider what they have learned about Indigenous people and their understanding of the history of Canada.
2. The Kairos Blanket Exercise takes participants through the history of assimilative government laws and policies so that participants experience a visceral reaction to the taking of land and the imposition of policies and laws, such as the Indian Residential School System.
3. Participants learn about the realities of access to justice for Indigenous people living in the North.
4. Participants learn about anti-bias and anti-racism strategies and are challenged to look at their own biases and assumptions relating to Indigenous people.
5. Activities and learning geared towards the day-to-day application of the previous modules to the work of the group.

Bimickaway uses an Indigenized and Indigenous methodological approach to its delivery. It is ideally delivered in settings of 25 people to ensure meaningful group discussions and activities. Bimickaway is co-led by one Indigenous facilitator and one non-Indigenous facilitator to model reconciliation. An Elder is invited to participate in at least one, and sometimes more modules, depending on scheduling, adding their meaningful life experiences to the curriculum.

**37. TBPS should ensure the Indigenous cultural competency training recommended in this report is accompanied by initiatives, in collaboration with First Nations police services that allow TBPS officers to train or work with First Nations police services and visit remote First Nations to provide outreach.**

- TBPS, in collaboration with First Nations Police Services, and with the approval of the applicable First Nation, should establish an exchange or secondment initiative to enable selected TBPS officers to visit or work for short periods in remote Indigenous communities.
- TBPS should ensure greater participation by front-line and senior TBPS officers in attending remote Indigenous communities as part of a larger outreach program to Indigenous youth. Some TBPS officers, particularly Aboriginal Liaison Officers, have attended remote communities to speak to youth who intend to come to Thunder Bay for education. I recognize that resources represent an impediment to greater use of this important initiative; however, it is a commendable way to build trusting relationships between TBPS and Indigenous people.
- TBPS should develop joint training with First Nations Police Services. This would allow TBPS officers to be introduced to the experiences and backgrounds of officers from First Nations Police Services.



I recognize that a number of TBPS officers volunteer, on their own time, to work with youth – including Indigenous youth. Many of the officers we interviewed expressed the need to go out into the community and build relationships instead of responding only to calls and crises.

Community members also strive to build positive relationships with police officers. They want officers to be out in their community and to build rapport and trust. Volunteering at community events provides opportunities for sustained relationship-building with Indigenous people.

- 38. TBPS leadership should provide greater support for voluntarism by attending relevant sporting or community events.**

Such support should include joint sponsorships of community events, and participation or attendance by senior management and rank-and-file officers (other than Aboriginal Liaison Unit officers) at such events on a regular basis.

- 39. TBPS should develop and enhance additional cultural awareness training programs relating to the diverse community it serves.**

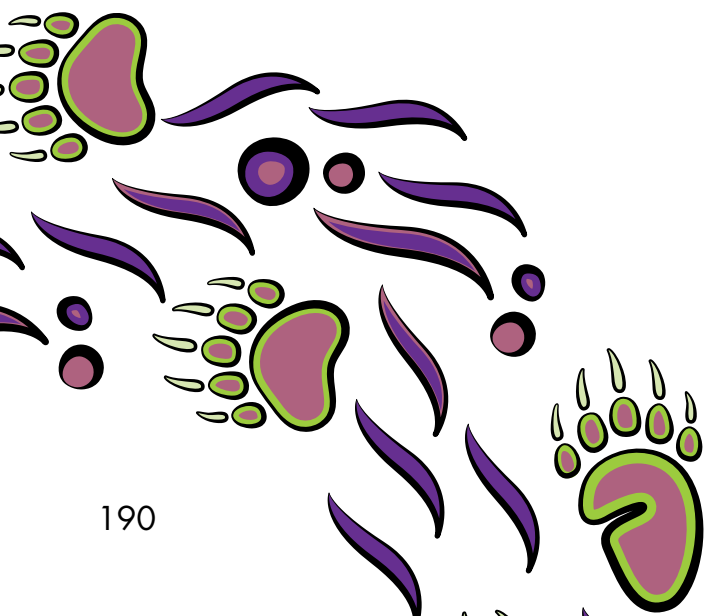
## RECOMMENDATIONS ON RACISM IN TBPS POLICING – RECRUITMENT AND JOB PROMOTION

### Hiring

- 40. TBPS should implement psychological testing designed to eliminate applicants who have or express racist views and attitudes. In Ontario, such specific testing is not done. It can be tailored to the TBPS experience. This testing should be implemented in Thunder Bay on a priority basis.**

Police services in Ontario generally include psychological assessments in their recruitment processes. These assessments can help identify candidates who exhibit personality traits and characteristics that may be problematic in a police workplace. The MMPI-2 (Minnesota Multiphasic Personality Inventory-2) assessment used in some police services does not assess attitudes to race. A specific assessment for racist attitudes is not done in Thunder Bay.

During the course of this review we met with one company, Multi-Health Systems Inc. (MHS), which has a well-established track record of designing psychological assessment tools. MHS has designed a psychological assessment for use in weeding out potentially racist policing candidates. Its psychological assessment is currently used in Quebec and in some American jurisdictions.



We were assured that these tools can be tailored to the Thunder Bay policing environment. It is not terribly expensive. I see no impediment to the introduction of psychological assessments specifically targeting racism, on a priority basis. Its use would not only assist in identifying problematic future officers, but promote confidence in TBPS.

**41. TBPS should, on a priority basis, create and adopt a proactive strategy to increase diversity within the service, with prominence given to Indigenous candidates.**

There was a consensus among both police and community stakeholders that TBPS should take measures to increase the number of Indigenous officers within the service.

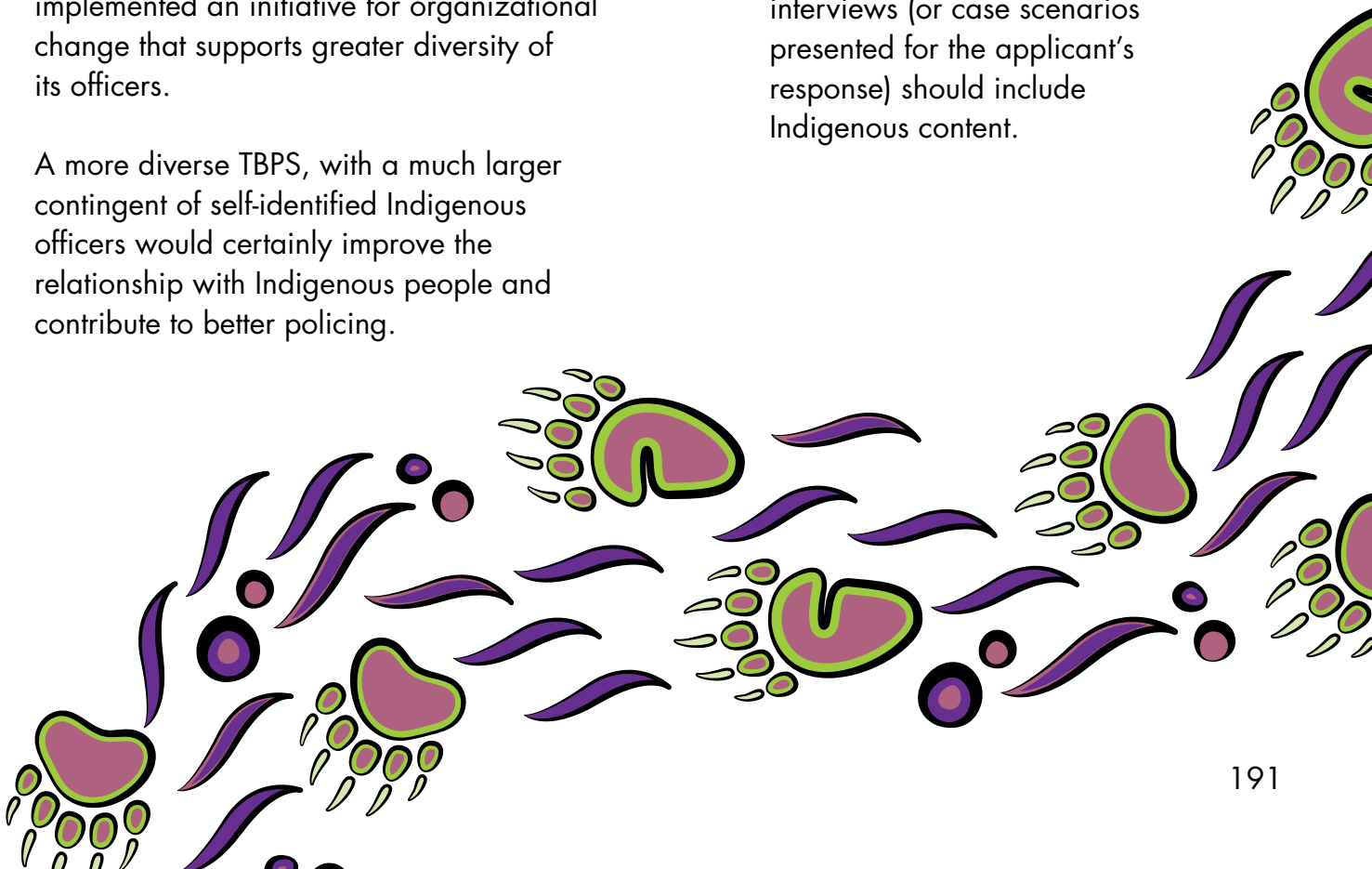
There has not been any strategy in place to recruit more Indigenous officers within the service. However, TBPS has indicated it has implemented an initiative for organizational change that supports greater diversity of its officers.

A more diverse TBPS, with a much larger contingent of self-identified Indigenous officers would certainly improve the relationship with Indigenous people and contribute to better policing.

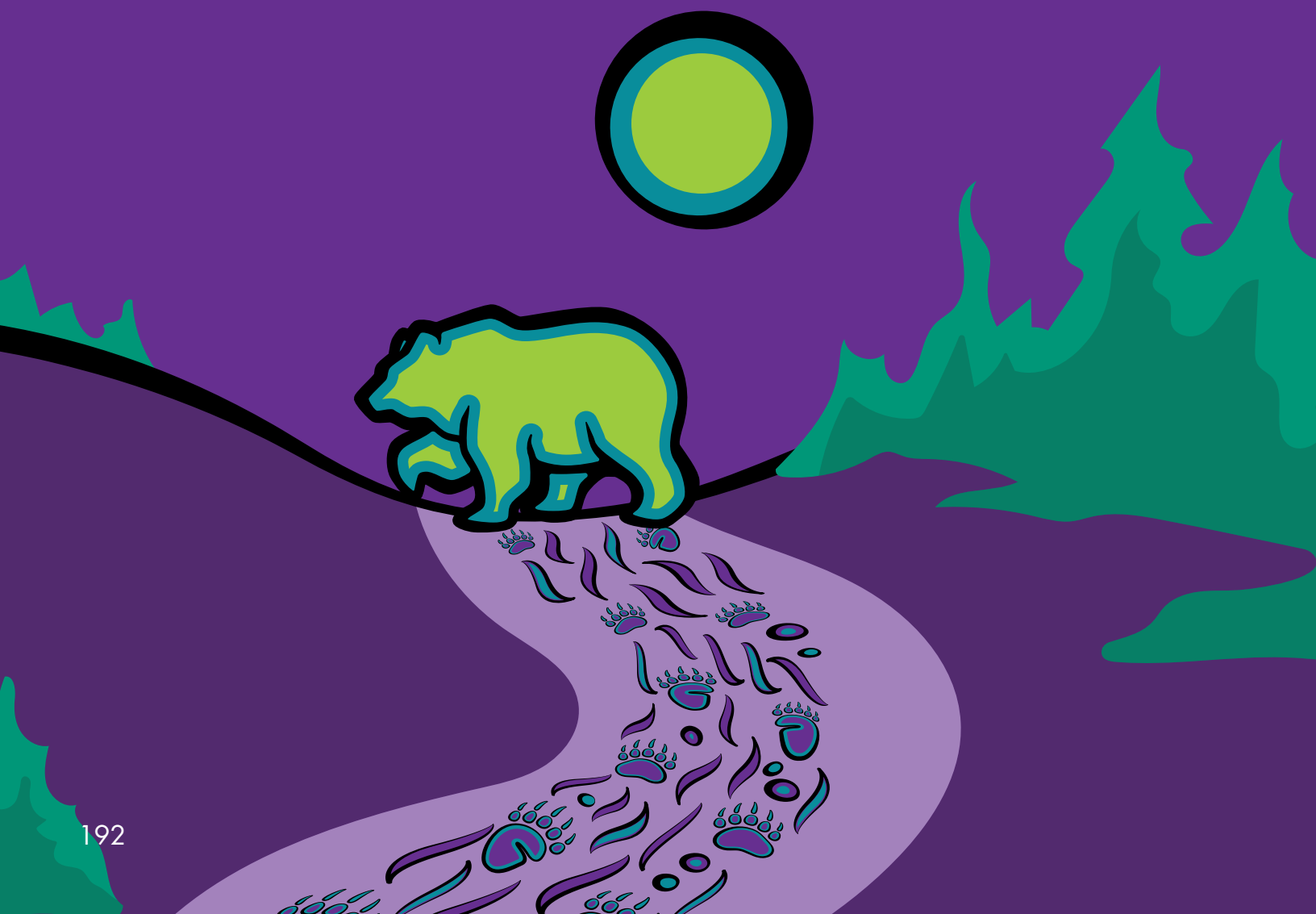
## Job Promotion

**42. TBPS leadership should link job promotion to demonstrated Indigenous cultural competency.**

- This means:
  - Applications for promotion (or selection to join certain units) should include a section on Indigenous cultural competency. Applicants should be expected to identify training, education, participation in secondments or exchanges that provide support for the cultural competence of the applicant officer or employee.
  - Criteria for promotion should include participation in mandatory and/or discretionary training, education, secondments or exchanges.
  - Questions posed at promotional interviews (or case scenarios presented for the applicant's response) should include Indigenous content.



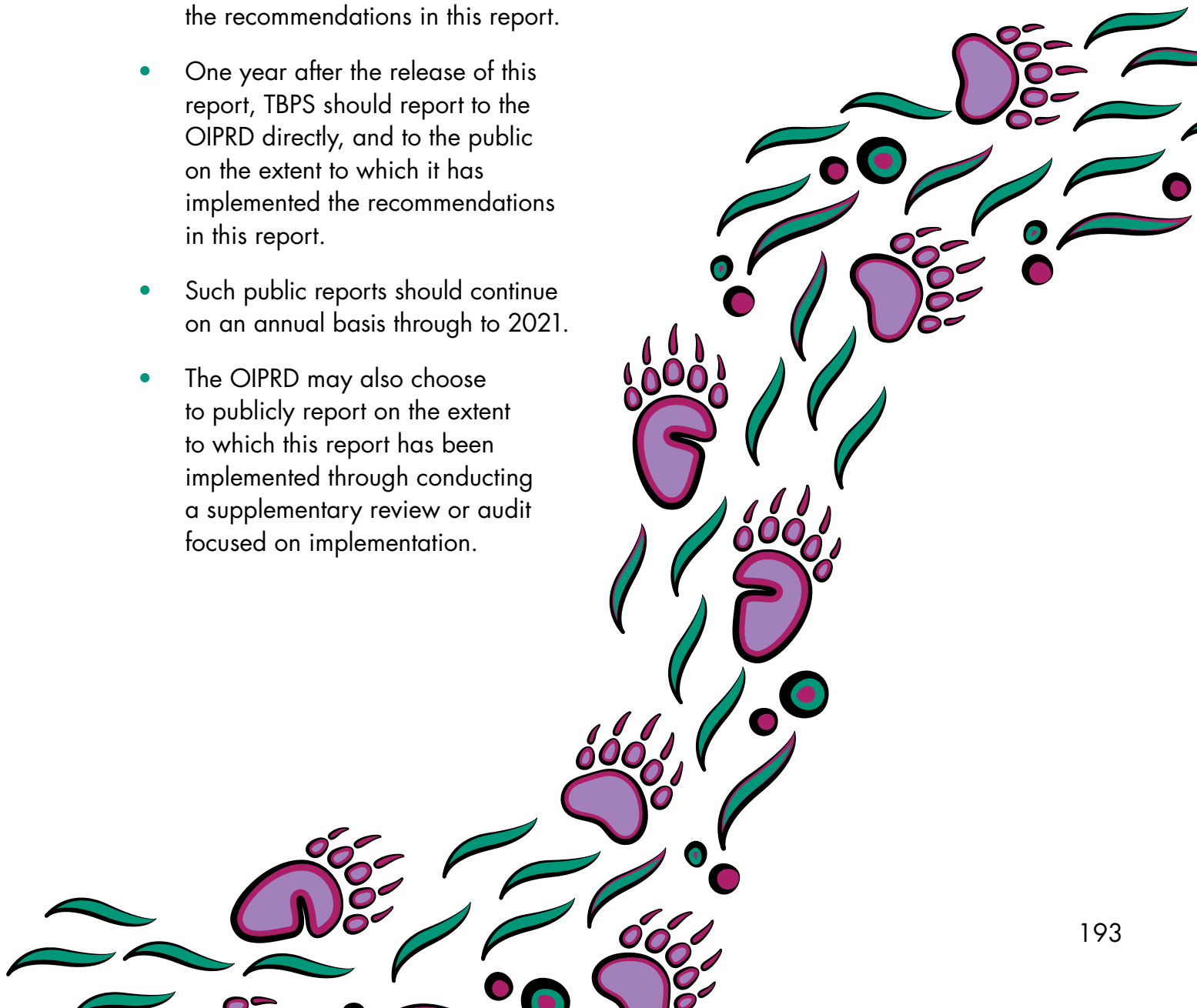
# CHAPTER 10: RECOMMENDATIONS FOR IMPLEMENTATION OF RECOMMENDATIONS



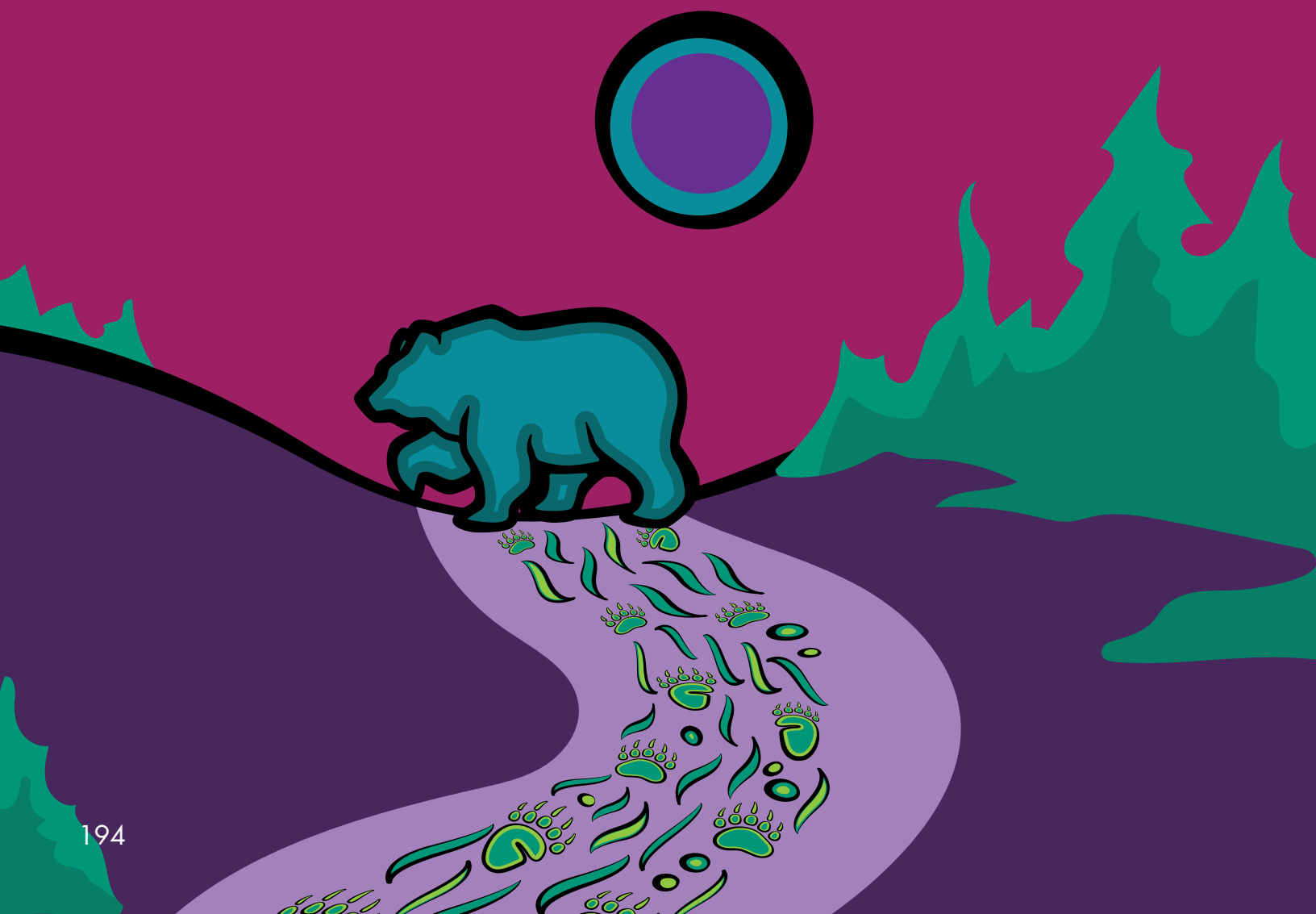
**43. Thunder Bay Police Service should report to the OIPRD on the extent to which the recommendations in this report are implemented. This is imperative given the crisis in confidence described in this report. The OIPRD should, in turn, report publicly on TBPS's response and the extent to which the recommendations in this report are implemented.**

- This means, among other things, that:
  - Six months after the release of this report, TBPS should provide the OIPRD with an interim report on the extent to which it has implemented the recommendations in this report.
  - One year after the release of this report, TBPS should report to the OIPRD directly, and to the public on the extent to which it has implemented the recommendations in this report.
  - Such public reports should continue on an annual basis through to 2021.
  - The OIPRD may also choose to publicly report on the extent to which this report has been implemented through conducting a supplementary review or audit focused on implementation.

**44. On an annual basis, TBPS should provide the public with reports that provide data on sudden death investigations. These reports can provide data, in a disaggregated Indigenous and non-Indigenous manner, detailing the total number of sudden death investigations with a breakdown of investigative outcomes, including homicide, accidental death, suicide, natural death and undetermined.**



# CHAPTER 11: CONCLUSION



I am indebted to those community members and organizations who have shared their views freely as to how the Thunder Bay Police Service can move forward in a respectful way to improve its relationship with Indigenous communities. This was a painful exercise for a number of Indigenous people, sometimes burdened by their knowledge that the issues identified in this report remain, despite report after report and despite vocalizing their deep concerns for many years. It was particularly painful for those whose loved ones have gone missing or have been found dead, with little or no confidence in the investigations that followed. We cannot lose an opportunity – yet again – to make real change.

I am also indebted to those officers, former and current, who care about how TBPS serves Indigenous communities, and support initiatives to promote anti-racist and effective policing. They too welcome an opportunity to improve the relationship between TBPS and Indigenous communities.

In my view, that relationship can only be improved through fundamental changes in how TBPS, including its senior management, performs its duties. Indigenous communities do not – and cannot – accept on faith that TBPS is committed to institutional and systemic change. The history and legacy of police services' involvement in implementing shameful government policies heighten the difficult relationship with police services generally. The serious deficiencies in how TBPS has investigated Indigenous missing persons and sudden or unexpected deaths has strained what was already a deeply troubled relationship.

Despite all that, there is some cause for optimism. TBPS has undertaken important initiatives to address its relationship with Indigenous communities. As well, I was encouraged by the respectful and constructive dialogue that took place at our public forum. Indigenous and non-Indigenous community members, as well as TBPS police officers, sat together and discussed how to move forward in a positive way. I believe that such continuing community engagement represents an important aspect of change.

However, meaningful change must come with a public formal acknowledgement by TBPS of the serious deficiencies in how it investigated Indigenous missing persons and sudden or unexpected deaths. It must also come with public acknowledgement by TBPS that systemic racism within the service is truly an issue that must be addressed and prioritized. Although some officers regarded this as a non-issue, the evidence, including input from some former and current TBPS officers, overwhelmingly supports the existence of racism, and the need for fundamental remedial action.

In order to improve its relationship with Indigenous communities, TBPS must ensure that its investigations are timely, effective and non-discriminatory. My recommendations are designed to prioritize that objective. As well, Indigenous cultural competency and anti-racism education and training must be embedded in the culture of the organization and delivered by the community. It cannot, as one senior officer pointed out, simply be regarded as “the flavour of the month,” but track the full career of TBPS officers. It must be designed to ensure that officers feel free to discuss bias, discrimination and racism. It

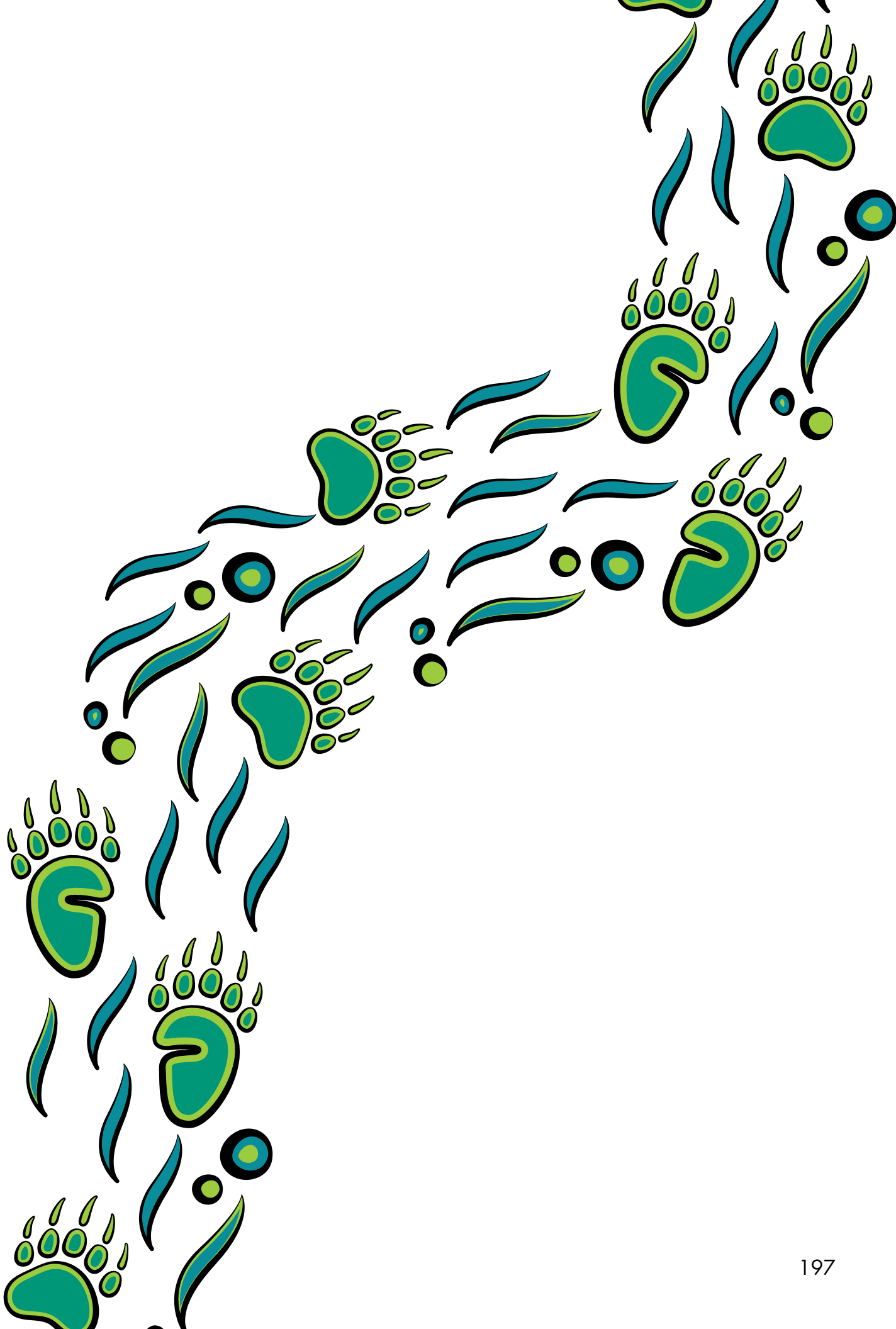
must be delivered in a respectful and positive environment and be relevant to how officers interact with Indigenous people on a day-to-day basis. It is important that Indigenous cultural competency and anti-racism figures prominently in promotional decisions – this means, among other things, that promotional interviews include cultural competencies, anti-racism strategies and scenarios on how to engage with Indigenous people when crises occur.

It also means that senior management must make consistent efforts to establish respectful relationships with Indigenous leadership. Rather than wait for Indigenous leadership to initiate contact when crises occur, senior management must initiate dialogue with Indigenous leadership on a regularized basis and seek advice when crises occur.

Thunder Bay has the dubious distinction of having one of the highest rates of reported hate crimes in Canada. This means, among other things, that greater efforts have to be made to ensure that recruits and new officers are not already imbued with racist attitudes. Some psychological assessments of applicants/recruits is currently done. But it is largely focused on other issues – such as the potential to misuse force or authority. Specific psychological assessments geared to weeding out racist attitudes now exist – and should be incorporated into TBPS's due diligence on a priority basis.

I finish where I started. We cannot lose this opportunity to improve the relationship between TBPS and Indigenous communities. I believe that the recommendations contained in this report provide tools to enable that relationship to significantly improve. I intend to provide this report to all police services in Ontario. I hope that it will assist them in their own roles in building positive relationships with Indigenous communities.

But my work is not done. I will continue to monitor how and to what extent my recommendations, as well as those initiatives identified by TBPS are implemented, and will report to the public on that implementation. The people of Thunder Bay are entitled to no less. That represents my commitment to Indigenous people, the Thunder Bay Police Service and the broader community it is responsible for serving.





# Endnotes

## Chapter 1

- <sup>1</sup> "Native group demands probe of unsolved deaths." *The Toronto Star* (Toronto), November 23, 1993, A17. As It Happens. "Former Ontario Police Board Member Called for Missing and Murdered Women Inquiry in 1993." CBC. December 11, 2015. <https://www.cbc.ca/radio/asithappens/as-it-happens-thursday-edition-1.3359164/he-s-the-former-ontario-police-board-member-who-called-for-a-missing-murdered-women-inquiry-in-93-1.3359651>
- <sup>2</sup> Kemp, David D. "Thunder Bay." In *The Canadian Encyclopedia*. Toronto: Historica Canada, 2012. <http://www.thecanadianencyclopedia.ca/en/article/thunder-bay/>
- <sup>3</sup> Statistics Canada. 2017. *Thunder Bay, CY [Census subdivision], Ontario and Ontario [Province] (table). Census Profile*. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Ottawa. Released November 29, 2017. <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CSD&Code1=3558004&Geo2=PR&Code2=35&Data=Count&SearchText=Thunder%20Bay&SearchType=Begins&SearchPR=01&B1=All&TABID=1>
- <sup>4</sup> Statistics Canada. 2016. *Aboriginal Peoples Highlight Tables, 2016 Census, Aboriginal identity population by both sexes, total - age, 2016 counts, Canada and census metropolitan areas and census agglomerations, 2016 Census – 25% Sample data*. Statistics Canada Catalogue no. 98-402-X2016009. Ottawa. Released October 25, 2017. <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hltfst/abo-aut/Table.cfm?Lang=Eng&T=102&S=8&O=A&RPP=9999>
- <sup>5</sup> Environics Institute. *Urban Aboriginal Peoples Study, Thunder Bay Report*. Toronto: Environics Institute, 2011. <https://www.uaps.ca/wp-content/uploads/2010/02/UAPS-Thunder-Bay-report.pdf>
- <sup>6</sup> Environics Institute. *Urban Aboriginal Peoples Study, Thunder Bay Report*.
- <sup>7</sup> Statistics Canada. 2017. *Police-Reported Hate Crime in Canada, 2015*. Statistics Canada Catalogue no. 85-002-X. Ottawa. Released June 13, 2017. <https://www150.statcan.gc.ca/n1/pub/85-002-x/2017001/article/14832-eng.htm>

- <sup>8</sup> Rudin, Jonathan, *Aboriginal People and the Criminal Justice System*; research paper commissioned by the Ipperwash Inquiry, 2007, 36-40.
- <sup>9</sup> Rudin, Jonathan, *Aboriginal People and the Criminal Justice System*, 28-36.
- <sup>10</sup> Indian Act, 1985, c.l-5. <https://laws-lois.justice.gc.ca/eng/acts/i-5/>

## Chapter 2

- <sup>11</sup> Royal Commission on Aboriginal Peoples. *Report of the Royal Commission on Aboriginal Peoples Volume 1 – Looking Forward, Looking Back*. Ottawa: Canada Communications Group, 1996. 259. <http://data2.archives.ca/rcap/pdf/rcap-490.pdf>.
- <sup>12</sup> Royal Commission on Aboriginal Peoples. *Report of the Royal Commission on Aboriginal Peoples Volume 1 – Looking Forward, Looking Back*, 173.
- <sup>13</sup> Ibid, 176.
- <sup>14</sup> Kemp, David D. "Thunder Bay." In *The Canadian Encyclopedia*. Toronto: Historica Canada 2012. <http://www.thecanadianencyclopedia.ca/en/article/thunder-bay/>
- <sup>15</sup> Hall, Anthony J. "Royal Proclamation of 1763", *Canadian Encyclopedia*. Toronto: Historica Canada 2012 <https://www.thecanadianencyclopedia.ca/en/article/royal-proclamation-of-1763/>
- <sup>16</sup> Surtees, Robert J. "The Robinson Treaties (1850)." *Treaties and Historical Research Centre Indian and Northern Affairs Canada, 1986*. <https://www.aadnc-aandc.gc.ca/eng/1100100028974/1100100028976#chp2>
- <sup>17</sup> Ibid.
- <sup>18</sup> Ibid.
- <sup>19</sup> Fort William First Nation, *The Importance of the Duty to Consult & Accommodate*, 2016. [https://fwfn.com/wp-content/uploads/2016/12/FWFN\\_ConsultationBook-Nov2016-single-reduced.pdf](https://fwfn.com/wp-content/uploads/2016/12/FWFN_ConsultationBook-Nov2016-single-reduced.pdf).
- <sup>20</sup> Royal Commission on Aboriginal Peoples. *Report*, 166.
- <sup>21</sup> Ibid, 254-255, 258, 260-261, 272.

- 22 Ibid, 265-274.
- 23 Indian Act, c. I-5.
- 24 Royal Commission on Aboriginal Peoples, *Report*, 256-257, 267, 276.
- 25 Ibid., 185-189, 296.
- 26 Fort William First Nation, "FWFN Consultation Book." 2016. [https://fwfn.com/wp-content/uploads/2016/12/FWFN\\_ConsultationBook-Nov2016-single-reduced.pdf](https://fwfn.com/wp-content/uploads/2016/12/FWFN_ConsultationBook-Nov2016-single-reduced.pdf)
- 27 Ibid.
- 28 Kemp, Thunder Bay, 2012.
- 29 Rasporich, Anthony W. "Twin City Ethnopolitics: Urban Rivalry, Ethnic Radicalism and Assimilation in the Lakehead." *Urban History Review*, 1990, 18(3), 210-230.
- 30 National Defence and the Canadian Forces. "Aboriginal People in the Canadian Military Chapter Five: The World Wars," 2008. <http://www.cmp-cpm.forces.gc.ca/dhh-dhp/pub/boo-bro/abo-aut/chapter-chapitre-05-eng.asp>
- 31 Sheffield, R. Scott. "Indigenous Peoples and the War Years." *The Canadian Encyclopedia*, 2016. <https://www.thecanadianencyclopedia.ca/en/article/indigenous-peoples-and-the-world-wars/>
- 32 Sheffield, *Indigenous Peoples*, 2016.
- 33 McDougall, Robert L. "Duncan Campbell Scott." *The Canadian Encyclopedia*, 2018. <https://www.thecanadianencyclopedia.ca/en/article/duncan-campbell-scott/>
- 34 McDougall, *Duncan Campbell*, 2018.
- 35 Royal Commission on Aboriginal Peoples, *Report*, 187.
- 36 Truth and Reconciliation Commission of Canada. "Canada's Residential Schools: The Legacy: The Final Report of the Truth and Reconciliation Commission of Canada. Volume 5." Winnipeg: *Truth and Reconciliation Commission of Canada*, 2015. 190 [http://www.myrobust.com/websites/trcinstitution/File/Reports/Volume\\_5\\_Legacy\\_English\\_Web.pdf](http://www.myrobust.com/websites/trcinstitution/File/Reports/Volume_5_Legacy_English_Web.pdf).
- 37 National Centre for Truth and Reconciliation, "St Joseph's (Fort William IRS) School Narrative." University of Manitoba, 2006. <https://nctr.ca/School%20narratives/EAST/ON/FORT%20WILLIAM.pdf>.
- 38 National Centre for Truth and Reconciliation, *St. Joseph's*, 2006.
- 39 Truth and Reconciliation Commission of Canada. "Canada's Residential Schools: The History, Part 2 1939 to 2000. The Final Report of the Truth and Reconciliation Commission of Canada. Volume 1." Winnipeg: *Truth and Reconciliation Commission of Canada*, 2015. 204. [http://nctr.ca/assets/reports/Final%20Reports/Volume\\_1\\_History\\_Part\\_2\\_English\\_Web.pdf](http://nctr.ca/assets/reports/Final%20Reports/Volume_1_History_Part_2_English_Web.pdf).
- 40 Truth and Reconciliation Commission of Canada, *Canada's Residential Schools*, 2015. 204.
- 41 Truth and Reconciliation Commission of Canada, *Canada's Residential Schools*, 2015. 204-205.
- 42 Truth and Reconciliation Commission of Canada. "The Survivors Speak: A Report of the Truth and Reconciliation Commission of Canada." Winnipeg: *Truth and Reconciliation Commission of Canada*, 2015. 113. [http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Survivors\\_Speak\\_2015\\_05\\_30\\_web\\_o.pdf](http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Survivors_Speak_2015_05_30_web_o.pdf).
- 43 *Fontaine v. Canada (Attorney General)*, 2014 ONSC 283 (CanLII) at paras 105-106.
- 44 *Fontaine v. Canada (Attorney General)*, 2014 ONSC 283 (CanLII) at para 105.
- 45 Royal Commission on Aboriginal Peoples, *Report*, 277.
- 46 Rudin, Jonathan. "Aboriginal People and the Criminal Justice System." *Commissioned by the Ipperwash Inquiry*, 2007, 26.
- 47 Niigaanwewidam James and Sinclair, Dainard Sharon. "Sixties Scoop." *The Canadian Encyclopedia*, Toronto: Historica Canada, 2016; edited 2017. <https://www.thecanadianencyclopedia.ca/en/article/sixties-scoop/>
- 48 Leslie, John F. "Indigenous Suffrage." *The Canadian Encyclopedia*, Toronto: Historica Canada, 2016. <https://www.thecanadianencyclopedia.ca/en/article/indigenous-suffrage/>.
- 49 First Nations & Indigenous Studies. "The White Paper 1969." *The University of British Columbia*, 2009. [https://indigenousfoundations.arts.ubc.ca/the\\_white\\_paper\\_1969/](https://indigenousfoundations.arts.ubc.ca/the_white_paper_1969/)
- 50 Thunder Bay Police Service. About Us – History, 2018. <https://www.thunderbaypolice.ca/about-us/history>.

- 51 Ibid.
- 52 Ibid.
- 53 Thunder Bay Police Service. About Us – Organization Chart, 2018. <https://www.thunderbaypolice.ca/about-us/about-us/basic-page>.
- 54 Thunder Bay Police Services. About Us – Core Functions, 2018. <https://www.thunderbaypolice.ca/about-us>.
- 55 “Point In Time Count 2018.” *Lakehead Social Planning Council*, 2018. <https://www.lspc.ca/point-in-time-count-2018/>
- 56 Rudin, Aboriginal People and the Criminal Justice System, 28.
- 57 Casey, Kim. “Thunder Bay City’s True Murder Investigations: 1882-2014.” Canada: *Ahneen Publishing*, 2014, 260.
- 58 Koivisto, Mickey. “Ontario Chiefs support probe of murders.” *Thunder Bay Post*, June 25, 1994.
- 59 Casey, *Thunder Bay*, 260-263.
- 60 “Natives demand action on murder cases.” *The Chronicle-Journal*, November 11, 1993.
- 61 Platiel, Rudy. “Police accused of ‘systemic racism’ Group calls for inquiry into unsolved killings of Thunder Bay Natives.” *The Globe and Mail*, November 27, 1993.
- 62 Koivisto, Ontario Chiefs support, 1994.
- 63 Ibid.
- 64 Casey, *Thunder Bay*, 172.
- 65 Ibid.
- 66 Platiel, Police accused of ‘systemic racism’, 1993.
- 67 Ibid.
- 68 Office of the Chief Coroner. “Verdict of Coroner’s Jury, Seven First Nations Youths.” *Ontario Ministry of Community Safety & Correctional Services, Office of the Chief Coroner Inquests*, 2016. <https://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/Inquests/Verdictsandrecommendations/OCCVerdictsSevenFirstNationsYouths.html>.
- 69 Ibid.
- 70 Gandhi, Unnati. “Native community angry after police question teen about shirt; Chief says Thunder Bay incident reflects larger issue of racial profiling: ‘What crime did he commit other than being a native person?’” *The Globe and Mail*, December 4, 2007.
- 71 Gandhi, *Native community*, 2007.
- 72 Beaton, Brian. “Fort Severn First Nation youth files an official complaint concerning police misconduct in search.” *The Thunder Bay Chronicle-Journal*, February 11, 2008.
- 73 Gandhi, *Native community*, 2007.
- 74 Ibid.
- 75 Ibid.
- 76 Beaton, Fort Severn First Nation youth, 2008.
- 77 Ibid.
- 78 Ibid.
- 79 Labine, Jeff. “Controversial email.” *TBNewsWatch*, September 5, 2012. <https://www.tbnewswatch.com/local-news/controversial-email-392154>. CBC News, “Thunder Bay police ‘insulted’ by human rights complaint” (19 September 2012). <http://www.cbc.ca/news/canada/thunder-bay/thunder-bay-police-insulted-by-human-rights-complaint-1.1142935>.
- 80 Labine, Controversial email, 2012.
- 81 Birchbark, Shari Narine. “Police service argues “Fresh Breath” moniker a mistake, not racism.” Ontario Birchbark, 2012. <http://ammsa.com/publications/ontario-birchbark/police-service-argues-%E2%80%9Cfresh-breath%E2%80%9D-moniker-mistake-not-racism-0>.
- 82 Ibid.
- 83 Thunder Bay police ‘insulted’ by human rights complaint.” *CBC News*, September 19, 2012. <http://www.cbc.ca/news/canada/thunder-bay/thunder-bay-police-insulted-by-human-rights-complaint-1.1142935>.
- 84 Ibid.
- 85 Galloway, Gloria. “Thunder Bay sex assault, hate-crime probe sharpen focus on native women’s plight.” *The Globe and Mail*, January 2, 2013. <https://www.theglobeandmail.com/news/national/thunder-bay-sex-assault-hate-crime-probe-sharpen-focus-on-native-womens-plight/article6885373/>

- <sup>86</sup> The Idle No More movement began in 2012 as an Indigenous grassroots movement, and spread quickly across the country through rallies and protests against federal government bills, including Bill C-45, which Indigenous people believed eroded treaty and Indigenous rights.
- <sup>87</sup> Galloway, Gloria. "Thunder Bay."
- <sup>88</sup> "OPP conclude 'starlight tour' allegation false," CBC News, March 18, 2013. <https://www.cbc.ca/news/canada/thunder-bay/opp-conclude-starlight-tour-allegation-false-1.1406107>  
<http://www.wawataynews.ca/home/thunder-bay-starlight-tour-allegations-untrue>
- <sup>89</sup> "'Thunder Bay Dirty' Facebook Page Sparks Police Investigation, Anti-Racism Rally." *The Huffington Post Canada*, May 5, 2015. [https://www.huffingtonpost.ca/2015/05/15/thunder-bay-dirty-first-nations-facebook-\\_n\\_7154476.html](https://www.huffingtonpost.ca/2015/05/15/thunder-bay-dirty-first-nations-facebook-_n_7154476.html)  
<https://www.thestar.com/news/canada/2015/12/08/one-rape-a-hate-crime-thunder-bays-simmering-divides-come-to-light.html>
- <sup>90</sup> Porter, Jody. "Thunder Bay police criticized for response to indigenous woman found naked on city street." CBC News, March 22, 2016. <http://www.cbc.ca/news/canada/thunder-bay/naked-woman-thunder-bay-police-1.3501149>
- <sup>91</sup> City of Thunder Bay. <https://www.thunderbay.ca/en/city-hall/walk-a-mile-film-project.aspx>.
- <sup>92</sup> City of Thunder Bay website. Accessed online: <https://www.thunderbay.ca/en/city-hall/walk-a-mile-film-project.aspx>.
- <sup>93</sup> Porter, Jody. "Thunder Bay police respond to allegations trainer was verbally assaulted in race-relations course." CBC News (Thunder Bay), September 14, 2016. <http://www.cbc.ca/news/canada/thunder-bay/police-thunder-bay-mmiiw-training-1.3761419>.
- <sup>94</sup> Ibid.
- <sup>95</sup> "Racism claim not backed up." *The Chronicle Journal*, September 15, 2016. [http://www.chroniclejournal.com/opinion/editorials/racism-claim-not-backed-up/article\\_ac7ac2a8-7abf-11e6-bb6a-238c8dd1e7a2.html](http://www.chroniclejournal.com/opinion/editorials/racism-claim-not-backed-up/article_ac7ac2a8-7abf-11e6-bb6a-238c8dd1e7a2.html).
- <sup>96</sup> Fiddler, Alvin. "No justifying police conduct." *The Chronicle Journal*, September 17, 2016. [http://www.chroniclejournal.com/opinion/letters\\_to\\_editor/no-justifying-police-conduct/article\\_2c7ea1e8-7c52-11e6-8760-3f5c5c7bb26e.html](http://www.chroniclejournal.com/opinion/letters_to_editor/no-justifying-police-conduct/article_2c7ea1e8-7c52-11e6-8760-3f5c5c7bb26e.html).
- <sup>97</sup> OIPRD. "Results of Disciplinary Hearings; Hearing Decision and Penalty Decision, 2018-03-13. <https://www.oiprd.on.ca/wp-content/uploads/SteudleRob-Plea-and-Penalty-03.13.18.pdf>
- <sup>98</sup> Ibid.
- <sup>99</sup> Ibid.
- <sup>100</sup> "Thunder Bay police officer suspended over allegedly making racist comments on indigenous people." APTN National News, October 5, 2016. <http://aptnnews.ca/2016/10/05/thunder-bay-police-officer-suspended-over-allegedly-making-racist-comments-on-indigenous-people/>.
- <sup>101</sup> "One officer suspended, 4 reassigned in investigation of Facebook posts." *The Chronicle-Journal*, October 5, 2016. [http://www.chroniclejournal.com/news/one-officer-suspended-reassigned-in-investigation-of-facebook-posts/article\\_dcd97992-8b2e-11e6-a754-d7b2885f3577.html](http://www.chroniclejournal.com/news/one-officer-suspended-reassigned-in-investigation-of-facebook-posts/article_dcd97992-8b2e-11e6-a754-d7b2885f3577.html).
- <sup>102</sup> APTN National News, *Thunder Bay police officer*, 2016.
- <sup>103</sup> OIPRD. "Results of Disciplinary Hearings; Hearing Decision and Penalty Decision, 2018-03-13. <https://www.oiprd.on.ca/wp-content/uploads/SteudleRob-Plea-and-Penalty-03.13.18.pdf>
- <sup>104</sup> OIPRD interview for systemic review. Thunder Bay. June 8, 2017. "First Nations man survived assault in Thunder Bay river, says woman who called police," CBC News (Thunder Bay) May 31, 2017. Accessed June 7, 2018. <https://www.cbc.ca/news/canada/thunder-bay/river-assault-1.4138343>
- <sup>105</sup> Thunder Bay Police Service. Systemic review submission to the OIPRD.
- <sup>106</sup> Vis, Matt. "Gangs a Growing Concern." *The Chronicle Journal* (Thunder Bay), January 18, 2017. [http://www.chroniclejournal.com/news/local/gangs-a-growing-concern/article\\_f97399c8-dd47-11e6-8657-57188cd46b8f.html](http://www.chroniclejournal.com/news/local/gangs-a-growing-concern/article_f97399c8-dd47-11e6-8657-57188cd46b8f.html)
- <sup>107</sup> Dixon, Nicole. "Indigenous representative to be added to police board." *TBNewsWatch* (Thunder Bay), December 20, 2016. <https://www.tbnewswatch.com/local-news/thunder-bay-police-services-board-voted-unanimously-493923>.
- <sup>108</sup> Thunder Bay Police Service. Systemic Review. Case disclosure to the OIPRD.

- <sup>109</sup> Porter, Judy. "Police fine First Nations woman for jaywalking after her skull was cracked in 'hit-and-run.'" *CBC News* (Thunder Bay), March 6, 2017. <http://www.cbc.ca/news/canada/thunder-bay/first-nations-jaywalking-1.4009028>.
- <sup>110</sup> Thunder Bay Police Service. Systemic Review. Case disclosure to the OIPRD.
- <sup>111</sup> "Tammy Keeash Investigation Update." *Thunder Bay Police Service*, May 12, 2017. <https://www.thunderbaypolice.ca/news/tammy-keeash-investigation-update>.
- <sup>112</sup> "Josiah Begg Investigation Update." *Thunder Bay Police Service*, May 23, 2017. <https://www.thunderbaypolice.ca/news/josiah-begg-investigation-update>.
- <sup>113</sup> Friesen, Joe. "First Nations plead for RCMP to address Thunder Bay 'policing crisis'." *Globe and Mail*, May 31, 2017. <https://www.theglobeandmail.com/news/national/first-nations-leaders-call-for-rcmp-to-probe-deaths-of-thunder-bay-teens/article35164124/>.
- <sup>114</sup> Bear Clan Patrol Thunder Bay. *Facebook*. [https://www.facebook.com/pg/BearClanTBay/about/?ref=page\\_internal](https://www.facebook.com/pg/BearClanTBay/about/?ref=page_internal)
- <sup>115</sup> Vis, Matt. "Memorial prayer walk about healing, not confrontation." *TBNewsWatch* (Thunder Bay), June 1, 2017. <https://www.tbnewswatch.com/local-news/memorial-prayer-walk-about-healing-not-confrontation-631752>.
- <sup>116</sup> NNL Staff. "OPP Commissioner Hawkes Statement on Thunder Bay Issues." *NetNewsLedger* (Thunder Bay), June 6, 2017. <http://www.netnewsledger.com/2017/06/06/opp-commissioner-hawkes-statement-thunder-bay-issues/>.
- <sup>117</sup> "TBPS News Conference: Realities and Challenges." *Thunder Bay Police Service*, June 7, 2017. <https://www.thunderbaypolice.ca/news/tbps-news-conference-realities-and-challenges>.
- <sup>118</sup> Fiddler, Willow. "A rock and a bit saved young man from abduction in Thunder Bay." *APTN National News*, June 8, 2017. <http://aptnnews.ca/2017/06/08/a-rock-and-a-bite-saved-young-boy-from-abduction-in-thunder-bay/>.
- <sup>119</sup> Statistics Canada. "Police-reported hate crime in Canada." Ottawa: *Government of Canada*, 2017. <https://www150.statcan.gc.ca/n1/pub/85-002-x/2017001/article/14832-eng.htm>.
- <sup>120</sup> Chekki, Chen. "I lost my son today." *Chronicle Journal* (Thunder Bay), June 26, 2017. [http://www.chroniclejournal.com/news/local/i-lost-my-son-today/article\\_07257b8a-5a30-11e7-9145-bbd4b37d886f.html](http://www.chroniclejournal.com/news/local/i-lost-my-son-today/article_07257b8a-5a30-11e7-9145-bbd4b37d886f.html).
- <sup>121</sup> "Incident Reporting." *Lakehead Social Planning Council*, 2018. <https://www.lspc.ca/incidentreport/>
- <sup>122</sup> "Update to Kevin Roundhead Homicide Investigation." *Thunder Bay Police Services*, July 8, 2017. <https://www.thunderbaypolice.ca/news/update-kevin-roundhead-homicide-investigation>
- <sup>123</sup> "SIU Investigating Death of Man in Thunder Bay." *Special Investigations Unit*, July 20, 2017. [https://www.siu.on.ca/en/news\\_template.php?nrId=3121](https://www.siu.on.ca/en/news_template.php?nrId=3121).
- <sup>124</sup> "Ontario Civilian Police Commission Appoints Investigator." *Safety, Licensing Appeals and Standards Tribunals Ontario*, July 24, 2017. <http://www.slasto.gov.on.ca/en/OCPC/Documents/TBPSB%20-%20Press%20Release%20-%20Investigator%20-%20FINAL%20-%20EN.pdf>.
- <sup>125</sup> Statistics Canada. "Police-reported crime statistics, 2016." Ottawa: *Government of Canada*, 2017. <https://www150.statcan.gc.ca/n1/daily-quotidien/170724/dq170724b-eng.htm>.
- <sup>126</sup> "Statement of Commitment to First Nation Youth and Families." *Nishnawbe Aski Nation*. <http://www.nan.on.ca/upload/documents/comms-2017-08-01-statement-of-commitment.pdf>.
- <sup>127</sup> Diaczuk, Doug. "Update: Death of 18-year-old ruled a homicide." *TBNewsWatch* (Thunder Bay), August 10, 2017. <https://www.tbnewswatch.com/local-news/death-of-18-year-old-ruled-a-homicide-693286>
- <sup>128</sup> "Thunder Bay police continue investigation into 'suspicious' death of Dylan Moonias." *CBC News*, December 15, 2017. <https://www.cbc.ca/news/canada/thunder-bay/dylan-moonias-investigation-update-1.4449099>.
- <sup>129</sup> Dunick, Leith. "Man pulled from the river in stable condition." *TBNewsWatch* (Thunder Bay), September 28, 2017. <https://www.tbnewswatch.com/local-news/man-pulled-from-river-in-stable-condition-728820>.
- <sup>130</sup> "Friendship agreement positive step forward: Chief." *Thunder Bay Police Service*. <https://www.thunderbaypolice.ca/news/friendship-agreement-positive-step-forward-chief>.

- <sup>131</sup> "Woman rescued from river." *Chronicle Journal* (Thunder Bay), October 2, 2017. [http://www.chroniclejournal.com/news/local/woman-rescued-from-river/article\\_d5b12528-a72c-11e7-a184-03b3d187c49b.html](http://www.chroniclejournal.com/news/local/woman-rescued-from-river/article_d5b12528-a72c-11e7-a184-03b3d187c49b.html).
- <sup>132</sup> "Teens rescued from Neebing River." *Thunder Bay Police Service*. <https://www.thunderbaypolice.ca/news/teens-rescued-neebling-river>.
- <sup>133</sup> Statistics Canada. "Aboriginal peoples in Canada: Key results from the 2016 Census." Ottawa: *Government of Canada*, 2017. <https://www150.statcan.gc.ca/n1/daily-quotidien/171025/dq171025a-eng.htm>.
- <sup>134</sup> Prokopchuk, Matt. "Brayden Bushby now charged with 2nd degree murder in death of Barbara Kentner in Thunder Bay, Ont." *CBC News* (Thunder Bay), November 3, 2017. <https://www.cbc.ca/news/canada/thunder-bay/brayden-bushby-2nd-degree-murder-1.4386008>.
- <sup>135</sup> Ontario Civilian Police Commission. "Interim Report of the Honourable Murray Sinclair submitted to the Executive Chair, Ontario Civilian Police Commission." Toronto: *Safety, Licensing Appeals and Standards Tribunals Ontario*, 2017. <http://www.slsto.gov.on.ca/en/OCPC/Documents/Final%20TBSPB%20Interim%20Report%20-%20Oct%2031%2c%202017.htm>.
- <sup>136</sup> Dunick, Leith. "Charges not expected in deaths of Tammy Keeash, Josiah Begg." *TBNewsWatch* (Thunder Bay), November 23, 2017. <https://www.tbnewswatch.com/local-news/charges-not-expected-in-deaths-of-tammy-keeash-josiah-begg-773987>.
- <sup>137</sup> "Shaping Our Future." *Thunder Bay Police Service*. <https://www.thunderbaypolice.ca/shaping-our-future>.
- <sup>138</sup> "Thunder Bay Police Seeking Fort William First Nation Artists." *Thunder Bay Police Service*. <https://www.thunderbaypolice.ca/news/thunder-bay-police-seeking-fort-william-first-nation-artists>.
- <sup>139</sup> "Thunder Bay police use-of-force up in 2017, report shows." *CBC News* (Thunder Bay), February 22, 2018. <https://www.cbc.ca/news/canada/thunder-bay/2017-use-of-force-1.4547538>.
- <sup>140</sup> Prokopchuk, Matt. "Thunder Bay newspaper apologizes for 'inconsiderate' headline on story about egg attacks on 2 men." *CBC News* (Thunder Bay), March 2, 2018. <https://www.cbc.ca/news/canada/thunder-bay/2017-use-of-force-1.4547538> <https://www.cbc.ca/news/canada/thunder-bay/national-assembly-apology-request-1.4557947>.
- <sup>141</sup> "Thunder Bay police investigate alleged racial violence after eggs thrown at pedestrians." *CBC News* (Thunder Bay), February 28, 2018. <https://www.cbc.ca/news/canada/thunder-bay/thunder-bay-egg-throwing-investigation-1.4555840>.
- <sup>142</sup> "Thunder Bay paper apologizes after AFN calls headline on egg attacks 'insensitive'." *Canadian Press*, March 2, 2018. <https://canoe.com/news/national/thunder-bay-paper-apologizes-after-afn-calls-headline-on-egg-attacks-insensitive>.
- <sup>143</sup> OIPRD, Results of Disciplinary Hearings, 2013.
- <sup>144</sup> "Shaping Our Future." *Thunder Bay Police Service*. <https://www.thunderbaypolice.ca/shaping-our-future>.

## Chapter 3

- <sup>145</sup> OIPRD, Results of Disciplinary Hearings, 2013.
- <sup>146</sup> Garrick, Rick. "Indigenous court opens in Thunder Bay." *Wawatay News*, March 11, 2017. <http://www.wawataynews.ca/politics/indigenous-court-opens-thunder-bay>.
- <sup>147</sup> Ibid.
- <sup>148</sup> Ibid.

## Chapter 4

- <sup>149</sup> In 2014, the Uniform Law Conference of Canada drafted a Uniform Missing Persons Act in an effort to support the development of provincial legislation regarding missing persons.

## Chapter 5

<sup>150</sup> Ontario. The Report of the Race Relations and Policing Task Force, Report by the Hon. Clare Lewis Toronto: *Race Relations and Policing Task Force*, 1989, 1.

<sup>151</sup> Ibid., 7.

<sup>152</sup> Police do little to solve crimes against her people, native says." *The Toronto Star*, February 18, 1989. A5 (ProQuest Historical Newspapers: The Toronto Star).

<sup>153</sup> Ontario, The Report of the Race Relations, 187-188.

<sup>154</sup> Ibid., 190.

<sup>155</sup> "Diversity in Policing Report." *Diversity Thunder Bay*, 2018. <http://www.diversitythunderbay.ca/?pgid=12>.

<sup>156</sup> Haluza-DeLay, Randolph. "A Community of Acceptance: Respect for Thunder Bay's Diversity." *Diversity Thunder Bay*, March 21, 2002, 73. <http://www.diversitythunderbay.ca/uploads/documents/A-Community-of-Acceptance.pdf>.

<sup>157</sup> Ibid., 128.

<sup>158</sup> Ibid.

<sup>159</sup> Pruegger, Valerie J. "Thunder Bay Police Service: Analysis of Policy & Procedure Manual." *City of Thunder Bay*, March 2007, 3.

<sup>160</sup> Ibid., 4-5.

<sup>161</sup> Diversity Thunder Bay, *Diversity in Policing*, 2018.

<sup>162</sup> Desmoulins, Leisa. "Diversity in Policing Project: Phase 1 report." *Diversity in Policing*, June 6, 2007, 7.

<sup>163</sup> Ibid., 7, 9, 15 -16.

<sup>164</sup> Ibid., 24.

<sup>165</sup> Interview with Leisa Desmoulins, January 30, 2018.

<sup>166</sup> Desmoulins, Leisa. "TBPS' Implementation Evaluation." 2008.

<sup>167</sup> Desmoulins, Leisa. "Thunder Bay Committee Against Racism and Discrimination: A Report on the Thunder Bay Plan for Action." *Diversity Thunder Bay*, 2009, 7.

<sup>168</sup> Ibid., 40.

<sup>169</sup> Ibid.

<sup>170</sup> Ibid., 41.

<sup>171</sup> Office of the Chief Coroner, *Verdict of Coroner's Jury*, 2016.

<sup>172</sup> Office of the Chief, *Inquest into the deaths*, 2016.

## Chapter 6

<sup>173</sup> The Criminal Investigations Branch has 51 officers. The General Investigations Unit within the Criminal Investigations Branch has 12 officers. (TBPS disclosure to the OIPRD).

<sup>174</sup> TBPS January 24, 2018 Submissions, pages 18-19

<sup>175</sup> TBPS January 24, 2018 Submissions, page 4

## Chapter 7

<sup>176</sup> A production order is a judicial authorization that compels a person or organization to disclose documents and records to police.

<sup>177</sup> The investigator told us that although the audio recording of the interview sounded as though C did all the talking, he and D were both talking at the same time. He also recognized the witnesses should ideally be separated, but that it was preferable to make these witnesses comfortable to obtain as much information as possible. The second officer involved said that the two witnesses were not in the car together. It is a valid point that in some instances, police must accommodate witnesses through less than ideal arrangements. However, we saw no meaningful steps taken to explain to the witnesses why it was preferable to speak to them separately. Equally important, in a number of the cases we reviewed, no formal interviews were conducted, despite the absence of any obvious rationale for failing to do so.

<sup>178</sup> "Post" means post-mortem (autopsy).

<sup>179</sup> K-net is a First Nations owned and operated information and communications technology (ICT) service provider that provides online applications in Northwestern Ontario.

<sup>180</sup> David, Jean-Denis. "Homicide in Canada, 2016," *Statistics Canada Juristat*, 2006, 6. <https://www150.statcan.gc.ca/n1/pub/85-002-x/2017001/article/54879-eng.pdf>.

## Chapter 8

<sup>181</sup> Statistics Canada. "Police Resources in Canada 2017," Ottawa: *Government of Canada*, 2018.  
<https://www150.statcan.gc.ca/n1/pub/85-002-x/2018001/article/54912-eng.htm>

<sup>182</sup> TBPS submission to the OIPRD September 2017.

<sup>183</sup> TBPS submissions to the OIPRD.

<sup>184</sup> "Ontario Forensic Pathology Service." *Ministry of Community Safety and Correctional Services*, May 8, 2018.

<sup>185</sup> *R. v. Williams*, [1998] 1 S.C.R. 1128 at para 21 and 22.

<sup>186</sup> *Williams*, *supra* at para 58.

<sup>187</sup> *McKay v. Toronto Police Services Board*, 2011 HRTO 499 (CanLII)

<sup>188</sup> *Phipps v. Toronto Police Services Board*, 2012 ONCA 396 *supra* note at para 34.

<sup>189</sup> *Phipps*, *supra* at para 47.

<sup>190</sup> *Peel Law Association v. Pieters*, 2013 ONCA 396 at para 65.

<sup>191</sup> *McKay v. Toronto Police Services Board*, 2011 HRTO 499 (CanLII).





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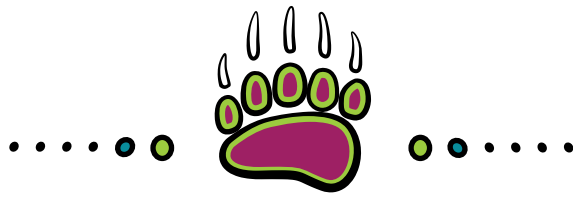
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