# Report-back to the Office of the Independent Police Review Director on the reinvestigation recommendations (1-4) identified in the Broken Trust Systemic Review

Submitted by the Executive Governance Committee

March 2022

## Report-back to the Office of the Independent Police Review Director includes:

- Letter to the Director, Office of the Independent Police Review Director
- Executive Governance Committee Terms of Reference
- Summary of Investigative Findings for Nine Reinvestigations
- Identification of 16 death cases warranting further investigation
- Recommendation for reinvestigation of the death of Stacy DeBungee

## Supporting Documents:

A: Comprehensive reports on each of the nine deaths

# Letter to the Director, Office of the Independent Police Review Director

March 1, 2022

Stephen Leach, Director
Office of the Independent Police Review Director
655 Bay Street, 10th Floor
Toronto, Ontario
M7A 2T4

Re: Office of the Independent Police Review Director (OIPRD) Broken Trust – Reinvestigations

Dear Director Leach:

We are writing to report back on the following four recommendations by the OIPRD in its Broken Trust report that were provided to the Thunder Bay Police Service (TBPS) and the Office of the Chief Coroner/Ontario Forensic Pathology Service (OCC/OFPS) regarding sudden death reinvestigations:

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

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.

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

4. The multi-discipline investigation team should also assess whether the death of Stacy DeBungee should be reinvestigated, based on our Investigative Report and the Ontario Provincial Police review of the TBPS investigation. The team should also assess when and how the investigations should take place, without prejudicing ongoing Police Services Act proceedings.

As you are aware, the Executive Governance Committee (EGC) was formed in September 2019 to develop an approach to respond to these recommendations. Its purpose was to develop a framework for reinvestigation of the nine cases identified by the OIPRD and consideration of other cases, including Stacy DeBungee. We have included the terms of reference (TOR) that outlines the purpose, structure, roles and responsibilities of those involved to provide you with that background information.

While the initial timeline for completion was Summer 2020, the past two years were marred with logistical challenges resulting from the COVID-19 pandemic. The investigative teams had to pivot their approach to coordinate virtual interviews and meetings when possible. The investigation process took

far longer than expected; however, we are satisfied that the additional time ensured thorough investigations in pursuit of the truths surrounding these deaths.

Now that the recommendations above are satisfied, the EGC is providing you a summary of findings for: the nine reinvestigations; our recommendation for additional death cases to be considered for independent reinvestigation; and the approach taken for the Stacy DeBungee case. In accordance with the TOR, the EGC will also be providing this information to the TBPS and the Thunder Bay Police Services Board. In addition to the case summaries, we have also included a supporting document that includes the nine comprehensive reports for each of the reinvestigations that have been redacted for the purpose of sharing with families. While it was intended that the lead investigators and Chief Coroner would meet with all families to discuss the findings in advance of the completion of our report-back to you, unfortunately, the pandemic restricted travel. In September and October, meetings were held with five families; however, we have been asked to suspend further meetings until April 2022. In the meantime, the investigation reports have been shared with the families by way of their support representatives with the exception of one report that required a recent addition. That family is aware the report will be provided late February/early March. We have been in touch with the remaining families and they prefer meeting in person instead of virtually, hopefully in April.

During the reinvestigation work and EGC discussions, it was recognized that a separate final report should also be prepared. The intention of the report is not to provide the level of detail contained in the nine reinvestigation reports; but instead, more broadly identify the results, lessons learned, input from families and Broken Trust team members, and provide recommendations based on the cumulation of all the information and interactions. An experienced writer was secured to lead writing the report and additional individuals were identified to work together to complete this task. While the premise of the reinvestigation response to the Broken Trust recommendations was based on collaboration, sharing and learning, evidence of systemic racism was recognized during the reinvestigation process as well as restriction of information and failure to equally share information with all investigative members, including the EGC. The occurrences created a challenging environment for the writing team to conduct their work in a meaningful, culturally safe manner.

Based on the feedback from the writers and advice provided by Indigenous members of the EGC, Investigative Resource Team and community leadership, there is a strong desire to produce a report that is meaningful, reflective, applicable, culturally respectful and trauma informed. It was decided that this task would be most appropriately positioned outside of the existing Broken Trust reinvestigation framework to ensure a fresh and unbiased approach. It was advised that the report not take on the tone of the reinvestigation reports; instead, be a learning tool that can assist in addressing the roots of the trauma involved in these cases and other police interactions to unveil the truths that are real and a pathway for healing and reconciliation for the families and communities.

The report writing will occur outside of the Broken Trust reinvestigation framework to ensure that those preparing the report have unfettered access to the materials gathered at all stages of the reinvestigation, including thoughts, experiences and recommendations made by those involved in the investigation process – the families and their supporters, the investigative teams, Indigenous

leadership and the EGC. This can be achieved and fits logically, and legally within the purview of a Chief Coroner commissioned report.

For this approach, the Chief Coroner is not part of the report preparation; rather, works with others to assemble a team under the authority of the Coroners Act to apply their expertise and knowledge to look at all relevant information and provide their assessments and recommendations. The subject matter expert group identifies the process of review and sets out the approach, organization, composition, and structure of the final product that provides their assessment, observations and (usually) recommendations leading to a pathway forward. The process is chosen by the group with either one or more assigned leads to guide the process. The 'report' is provided to the Chief Coroner and the group may, and does in some cases, provide a recommendation distribution plan and how to most appropriately share the findings. The EGC agrees this approach provides for a bias-free analysis of the materials from an Indigenous-led perspective. It is separate from the individual disciplinary oversight of EGC members (i.e. Chief Coroner, Chief Forensic Pathologist and Thunder Bay Police Chief).

We would be remiss not to mention the dedication and diligent work of the investigative and resource teams under the leadership of Detective Superintendent (retired) Kenneth Leppert. In addition to the police services that provided investigative services – Anishinabek Police Service, Nishnawbe Aski Police Services, OPP, Peel Regional Police, Royal Canadian Mounted Police, South Simcoe Police Service, TBPS, Treaty Three Police Service, expertise was also provided by members of the Ministry of the Attorney General, Baawaating Family Health Team, Centre of Forensic Sciences, the OCC/OFPS and the University of Toronto.

Being part of this process has been a humbling, and informative undertaking. The very issues that were identified in the Broken Trust Report were clearly illustrated throughout these reinvestigations. A key purpose of the Broken Trust reinvestigations was to learn from reinvestigating the deaths to determine if there were deficiencies in approaches that could lead to better investigations and truth-finding in the future. In seeking and identifying trends in approaches we are hopeful that the results of the investigations are taken seriously and lead to better investigative techniques in the future and potentially prevent further deaths.

It has been a great honour to be part of this very important undertaking and we are open to meeting with you to discuss our findings, experiences and any of the information included in this report-back.

Sincerely,

The Broken Trust Executive Governance Committee:
Chair: Justice Stephen Goudge
Members: Chief Sylvie Hauth, Dr. Dirk Huyer, Dr. Michael Pollanen, Helen Cromarty, Irene Linklater

**Broken Trust Recommendation #2: A multi-discipline investigation team should be established to undertake, at a minimum, the reinvestigation of the deaths of nine indigenous people identified.**

## TERMS OF REFERENCE
## STRUCTURE AND ROLES

**PURPOSE**

The Office of the Independent Police Review Director (OIPRD) recent report into investigations of deaths of First Nations people in Thunder Bay, "Broken Trust", identified systemic failings of death investigations. It recommended that nine of the cases that were reviewed be reinvestigated:

1. M.N. in Broken Trust
2. O.P. in Broken Trust
3. Q.R. in Broken Trust
4. S.T. in Broken Trust
5. C.D. in Broken Trust
6. G.H. in Broken Trust
7. A.B. in Broken Trust
8. E.F. in Broken Trust
9. I.J. in Broken Trust

In response, the Thunder Bay Police Service, the Office of the Chief Coroner and the Ontario Forensic Pathology Service prepared an independent, multi-disciplinary and multi-agency team approach that would use basic principles to reinvestigate these cases.

The goals of these enhanced investigations include:

- Truth-seeking and transparency
- Supporting the administration of justice
- Development of the Thunder Bay Police Service investigation team through application of best practices
- Enhancing professional collaboration among the partner agencies
- Community confidence in outcome/results of reinvestigations
- Restoring the confidence of the public and the affected communities and families

**REINVESTIGATION STRUCTURE**

A three-tiered oversight framework to manage and conduct the reinvestigations.

- Executive Governance Committee:
    - Nishnawbe Aski Nation (NAN) Grand Chief Alvin Fiddler *replaced by NAN Legal Services Director Irene Linklater
    - Honourable Justice Stephen T. Goudge
    - Dr. Dirk Huyer, Chief Coroner for Ontario
    - Dr. Michael Pollanen, Chief Forensic Pathologist for Ontario
    - Chief Sylvie Hauth, Chief of Thunder Bay Police Service
    - Ms. Helen Cromarty, First Nation Elder

- Investigative Resource Committee:
    - Dr. Kona Williams, Forensic Pathologist
    - Dr. Linda Kocovski, Forensic Pathologist
    - Dr. Annelind Wakegijig, Coroner
    - Dr. Barry McLellan, Investigating Coroner
    - Kimberly Murray, Assistant Deputy Attorney General, Indigenous Justice Division, Ministry of the Attorney General
    - Susan Orlando, Crown Attorney, Ministry of the Attorney General
    - Other expertise as required such as toxicologist, forensic identification officer, representatives to support families, etc.

- Blended Investigative Team:
    - Detective Superintendent Ken Leppert (retired OPP) - LEAD
    - Nishnawbe Aski Police Service (NAPS) Detective Constable
    - Thunder Bay Police Service (TBPS) Detective Constables (5)

**ROLES**

**Executive Governance Committee**

- Oversee the re-investigations
- Develop and approve the reinvestigation framework, procedures and terms of reference
- Track progress against key milestones
- Meet as required to complete necessary tasks
- Approve all completed reinvestigations
- Make public the reinvestigation findings as appropriate
- Brief senior officials and key stakeholders
- Make recommendations for future investigations as appropriate

**Investigative Resource Committee**

- Act as expert resources for the Blended Investigative Team

    - Sub-committees with particular expertise may be struck to respond to specific questions
- Provide support to Blended Investigative Team regarding:
    - Ensuring all existing information is obtained
    - Ensuring culturally safe trauma focused support is available to family members
- Meet at the discretion of the Blended Investigative Team, but no less than once every two months

**Blended Investigative Team**

- Conduct police reinvestigations
    - Gather all existing information regarding each of the nine cases:
        - coroner investigations
        - inquest briefs
        - police reports/files
    - Utilize Major Case Management principles to support the reinvestigations
- Each case to be investigated by the external police service appointee, plus one or more investigators from TBPS and NAPS
- Communicate with the affected communities and families
- Ensure support for families affected by the reinvestigation of the deaths (culturally safe trauma focused support)
- Report to the Investigative Resource Committee and Executive Governance Committee
- Share with the Executive Governance Committee additional cases identified during the reinvestigation work that, in the view of the team lead, would warrant further investigation

**CRITICAL PATH**

A one-year timeframe for the reinvestigations:

- **June 18, 2019**, obtain approval from the Thunder Bay Police Service Board
    - Announcement of the reinvestigation structure, framework and timelines
- **September to December 2019**, commence reinvestigation
    - September and December 2019, Blended Investigative Team meet with Investigative Resource Committee for update
- **January 2020**, all levels of reinvestigation meet with Executive Governance Committee for update
    - Update to be made public as appropriate
- **March and May 2020**, Blended Investigative Team meet with Investigative Resource Committee for update
- **July 2020**, all reinvestigations complete and final report presented to the Executive Governance Committee for review, approval and public release

**REINVESTIGATION COSTS AND RESOURCES**

- The Thunder Bay Police Service is responsible for the costs of the reinvestigations relating to:
    - adequate facilities and equipment
    - approved officer travel, meal and accommodation expenses in accordance with the policies of the TBPS
    - remuneration and expenses of any individual contractors (e.g., retired police officer(s) and judge), honorarium for Elder
- Culturally safe support for families will be arranged and funded through existing programs
- The partner agencies will contribute in-kind expertise and will cover the salary and benefits of participating members
    - Coverage for travel expenses to attend meetings may be subject to negotiation with the TBPS and in accordance with the policies of the TBPS

**CONFIDENTIALITY**

The participants agree to not to disclose or publish any information they receive without the prior consent of the Executive Governance Committee.

*** CONFLICT OF INTEREST**

The Executive Governance Committee will be consulted as necessary to address any emerging real or perceived conflicts of interest.
* NOTE: Further to the Terms of Refence, the EGC approved a Conflict of Interest Protocol in which the ECG agreed on a process whereby any member(s) may declare a Conflict of Interest and recuse themselves (e.g. if they had involvement in a case in question) or any member can raise a potential Conflict of Interest regarding another member(s). Either way, the matter is discussed by the EGC including the person with the real or perceived conflict of interest.

## PART B: PARAMETERS FOR REINVESTIGATION

The Executive Governance Committee has set the following parameters for reinvestigation to ensure a balanced, thorough and consistent reinvestigation of the nine deaths:

**A: INVESTIGATION TO COVER THE FOLLOWING THREE DOMAINS CONSISTENT WITH THE FIRST PRINCIPLES OF INVESTIGATION:**

1. **Factual:** Fully explore and reinvestigate the history, scene and circumstances of each of the deaths.
    - Discreet investigative tasks

- Natural history of the person
- What happened at the time of death and time leading into it – hours, days etc.

2. **Factual:** All medical and scientific aspects of the deaths must be reinvestigated by the coroner, forensic pathologist and forensic scientists
3. **Derive from facts:** multidisciplinary consensus-based opinion/analysis.
    - Reconstruction of the events leading to death and how the death occurred.
    - Nuanced analysis – Complete a wholistic analysis evaluating for intersections between the person, the examination, forensic testing findings and the circumstances of the death

➢ **OUTPUT:**
Look at the facts of all nine deaths both in isolation then in comparison to each other – similarities, trends.

The Executive Committee further expects:

1. Families need to be re-interviewed.
    - Potential information or theories the family or others may have need to be investigated.
    - Families must be provided culturally safe trauma informed support prior to, during and after discussions with the investigators
2. In addition, interviews need to be completed of any key witnesses/informants in the initial investigation or new ones that may come up in the re-investigation.
3. Scenes will all be revisited and photographically recorded.
    - Possible forensic mapping of the locations of the deaths. Evaluating for potential hazards that may identify opportunity for public safety enhancement.
    - Complete an analysis of each of the death scenes for similarities and common factors.

➢ **OUTPUT:**
Completed physical report that takes into account all of the above.

- Delivered to the Executive Committee for provision to the TBPS Board and can, at least in part, be made public.

Guiding Principle: It is necessary to ensure confidence in the ability to investigate and to reinvestigate without bias.

DATE: September 2019

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

## SUMMARY OF INVESTIGATIVE FINDINGS FOR THE NINE REINVESTIGATIONS

The nine deaths recommended for the reinvestigation took place between 2000 and 2017. For each of the reinvestigations, the team provided details of what was done during the investigations and the results of their findings. This included identifying any issues they found with the original investigations. One of the frequent observations was that Major Case Management (MCM) was not applied.

The Province of Ontario developed the Major Case Management (MCM) system in 1997 in partnership with the Ontario policing community. The impetus of MCM was to develop one standard case management system for use by all Ontario police services. This system was to allow a higher standard across the province, allow linked cases to be integrated and to promote cooperation and information sharing between law enforcement agencies. The MCM system outlines criteria offences to be deemed as major cases and made a distinction between threshold and non-threshold offences in which a Primary Investigator shall be deemed and MCM utilized.

In each major investigation a command triangle shall be formed consisting of Major Case Manager, Primary Investigator and File Coordinator. Specialized, Ministry approved software, called PowerCase, is to be utilized when investigating a major case. Each role has assigned duties. Very specific requirements are outlined in the Manual as it relates to scene investigation, forensic identification, field investigations and canvassing. In 2017, the MCM underwent numerous changes which expanded the offences that meet the threshold.

Threshold cases, as they existed prior to 2017, include homicides, not all sudden deaths, and missing person occurrences where the circumstances indicate a strong possibility of foul play. In 2017, offences were added as non-threshold offences which includes missing persons, where police have yet to ascertain whether foul play is involved when the individual remains outstanding and unaccounted for 30 days after being reported missing.

All of the Sudden Deaths referenced herein should be looked at in light of the above. Some may still not fall under the MCM model at this time.

## 1. M.N.: Death investigation summary of final report

**Deceased:** M.N.

**Reported Missing:** October 29, 2000

**Body Discovered:** November 11, 2000

**Incident Location:** Kaministiquia River Heritage park

**Cause and Manner of Death:** The initial cause of death (2000) was drowning and manner of death of accident. At the conclusion of the Coroner's Inquest (June 28, 2016) the Verdict of the Coroner's Jury concluded the cause of death was drowning and manner of death undetermined. This did not change as a result of the 2020-21 reinvestigation.

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**REINVESTIGATION**

**All Existing Documents Reviewed by the Investigative Team:**

- Environmental Information – assessment of the weather conditions during the period that M.N. was missing (sunrise, sunset and temperature)
- Original investigative files:
    - Audio/visual interviews
    - Coroner's Investigation Statement, Post-Mortem Report and Toxicology Report
- Ontario Provincial Police inquest preparation files which include:
    - 1050 files (audio/video interviews, written statements)
    - 785 pages of transcripts from the 2015 inquest
    - Transcripts from 183 individuals who were interviewed during the investigation.
    - Evidence and Exhibits from the investigation/inquest (articles of clothing and a note)
        - All items re-examined by the Forensic Identification Unit.
- Independent Review of Medical Examinations/investigation:
    - Conducted by coroner and forensic pathologist members of the Investigative Resource Committee
    - In addition, an investigating coroner from the Baawaating Family Health Team, completed an independent review of all forensic file related to the M.N. death investigation.
- Scene Re-Examination: May 6, 2020
- Investigated into the several stories in the community that were circulating following the death (drug/gang involvement, murdered by being weighted down by rocks; potential drug debts).

**INVESTIGATIVE ISSUES IDENTIFIED DURING REINVESTIGATION of ORIGINAL TBPS/CORONER INVESTIGATION:**

1. The scene was cleared immediately and not preserved

2. No request was made to obtain a copy of the video surveillance from the James Whalen Tug Boat. As a result, the video was overwritten and not able to be obtained.

3. M.N.'s clothing was placed in a garbage bag which was secured with a knot and string. The garbage bag was then placed inside a banker's box. A property tag was affixed to the exterior.

4. No crime scene continuity register was located within the investigative file. There was no mention of one being completed within a report.

5. There appears to have been minimal follow-up after the discovery of M.N.'s body, e.g. limited follow-up interviews.

6. There is no mention within the investigative file that a canvass had been completed.

7. No follow-up was completed pertaining to the conflicting information received from three key witnesses.

8. Limited discussions between the investigators, the Forensic Identification Unit, the coroner and the pathologist with regard to the injuries and findings.

9. The cause of death was drowning. The pathologist noted he had more investigative techniques to do before a final report was submitted. There is no report on file which indicates if any additional techniques were performed.

10. There is no report on file pertaining to the clothing that was seized by the investigators.

11. There appears to have been no consideration for forensic analysis of any of the exhibits.

12. The decision to bring in divers was at the discretion of the Thunder Bay Police command staff. When a family member made the request on November 4, 2000, he was told there was no evidence to suggest that M.N. was near the river at the time he went missing.

13. There was no underwater search for evidence after M.N. was located.

14. Several main witnesses, whom were with M.N. the day/night he went missing were never re-interviewed after the discovery of his body.

15. Two witnesses should have been cautioned prior to their interviews taking place as a result of investigators receiving information which suggested M.N. may have been assaulted the night he went missing.

16. Only four interviews were recorded by way of audio/video.

17. There is no indication within the file that there was discussion related to the injuries on M.N.

18. The investigation should have been treated as suspicious from the onset and Major Case Management practices should have been engaged.

## 2. C.D.: Death Investigation Summary of Final Report

**Deceased:** C.D.

**Dispatch Date/Time:** February 5, 2014 – 0921 hours

**Incident Location:** Thunder Bay, Ontario

**Cause and Manner of Death:** The cause of death was ligature by hanging and manner of death was deemed suicide. These findings were unchanged from those provided in the initial death investigation.

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**REINVESTIGATION**

**All Existing Documents Reviewed by the Investigative Team:**

- Original investigative files:
    - Audio/visual interviews (21)
    - Emergency Services – reports and recording
    - Coroner's Investigation Statement, Post-Mortem Report and Toxicology Report
- C.D.'s mother interviewed (January 2020). She had not been interviewed in the initial investigation. Names of several people C.D. was friends with before her death were provided.
- All evidence that was seized during the original investigation was reviewed – the ligature (belt) had not been subjected to forensic testing. Testing for DNA was completed at the Centre of Forensic Sciences (CFS).

**Scene Re-examination:**

- January 28, 2020 an extensive scene re-examination was conducted under the authority of a coroner on the Investigative Resource Team. The Thunder Bay Police Forensic Identification Unit assisted as well as the Unmanned Aircraft System (UAS) and an engineering firm using an anthropomorphic test device (ATD), or 'crash test dummy' to determine whether competing theories were possible.

**Independent Review of Medical Examinations/investigation:**

- Conducted by coroner and forensic pathologist members of the Investigative Resource Team.
- In addition, an investigating coroner from the Baawaating Family Health Team, completed an independent review of all forensic file related to the C.D. death investigation.
- In addition to the scene re-examination, Peel Regional Police Forensic Identification Service completed an independent review of all forensic evidence.
- Cellular Communication Device Extraction and additional investigative work.
- Key witnesses were re-interviewed.

**INVESTIGATIVE ISSUES IDENTIFIED DURING REINVESTIGATION of ORIGINAL TBPS/CORONER INVESTIGATION:**

1. The C.D. death investigation was problematic from the very start. When officers arrived on the scene, a key witness identified himself verbally and provided no photo identification to the officer. Furthermore, he was permitted to re-enter the apartment which should have been treated as a crime scene. As a result of allowing this potential person of interest re-enter the apartment, a cellular communication device was taken without the officer's knowledge. The device may have revealed evidence in relation to the death of C.D.

2. The individual left the apartment and attended the hospital which was confirmed by investigators. There was minimal effort put into locating this person who was presumed to be the last person with C.D. prior to her death. This person was not formally interviewed by investigators until years later. The person recalled a different version of events than what he initially told responding officers. Furthermore, the individual was arrested by TBPS on October 11, 2016. While in custody, he was never interviewed in relation to C.D.'s death.

3. After the Criminal Investigation Branch (CIB) arrived on scene, it appears that minimal discussion took place between them, the Forensic Identification Unit and the attending coroner. The death was determined to be non-suspicious resulting in no further investigative steps. These steps could have included a scene canvass to identify potential witnesses or video surveillance footage. During the reinvestigation, investigators located a surveillance camera however, the retention period was six months. Surveillance footage may have identified persons attending the apartment or provided pertinent information to the investigation.

4. Additional forensic work and photographs should have been completed at the scene. Investigators were unable to determine if C.D.'s hand touched the overhead pipe; however, they were able to confirm it was possible for C.D. to reach the pipe. Testing for blood and weight bearing should have been completed at the time of the incident.

5. The 9-1-1 recording was not retained as the investigation was determined to be non-suspicious. During the reinvestigation, investigators were unable to review the 9-1-1 recording due to the TBPS retention period being six months. This recording may have provided to be valuable information about the key witness.

6. None of the first responders were interviewed at the time of the incident. This is not usual practice when a death is deemed non-suspicious. Had the death been deemed suspicious and interviews completed, pertinent information may have been learned.

7. Investigators should have interviewed family and friends at the time of the incident. This would have helped to establish a timeline leading up to the events on February 5, 2014.

8. The investigation should have been treated as suspicious from the onset and Major Case management practices should have been engaged.

## 3. A.B.: Death Investigation Summary of Final Report

**Deceased:** A.B.

**Dispatch Date/Time:** March 29, 2016 at 0801 hours

**Incident Location:** North McKellar Street at William Street, along the McIntyre Ricer across from Sysco Foods located at 840 McKellar Street, North, Thunder Bay, Ontario

**Cause and Manner of Death:** Initial investigation – cause of death hypothermia and manner of death accident. Following the reinvestigation, this was changed to: cause of death hypothermia and ethanol intoxication in a woman with blunt force trauma; and manner of death provided as undetermined.

**REINVESTIGATION**

**All Existing Documents Reviewed by the Investigative Team:**

- Environmental Information – assessment of the weather conditions for the night of March 28, 2016 and early morning hours of March 29, 2016. Specifically, wind chill factor.
- Original investigative files:
    - Audio/visual interviews (13)
    - Coroner's Investigation Statement, Post-Mortem Report and Toxicology Report
    - Emergency Services reports and recordings, attending officer's notes

**Scene Re-examination:**

- March 26, 2020 an extensive scene re-examination was conduct under the authority of a coroner on the Investigative Resource Team. Thunder Bay Police Forensic Identification Unit assisted as well as the Unmanned Aircraft System (UAS) to provide an aerial grid and angled photographs of the scene.
- The TBPS FARO 3D program created a 3D representation of the area where A.B. was located, specifically the McIntyre River at the railway bridge.
- They also retraced the steps that she was believed to have taken prior to her death.

**Independent Review of Medical Examinations/investigation:**

- Conducted by coroner and forensic pathologist members of the Investigative Resource Team.
- In addition, an investigating coroner from the Baawaating Family Health Team, completed an independent review of all forensic file related to the A.B. death investigation.
- Included all medical records (over 6000 pages) that were seized under the authority of the coroner to determine whether any pre-existing conditions may have contributed to her death.
- CFS Toxicologist provided a letter of opinion based on and analysis of the toxicology report.
- CFS completed a full analysis of all property (clothing) and physical evidence samples from A.B.
- Conducted interviews with original witnesses and additional persons not interviewed at the initial investigation.

**INVESTIGATIVE ISSUES IDENTIFIED DURING REINVESTIGATION of ORIGINAL TBPS/CORONER INVESTIGATION:**

**Classification and Management:**

1. Major Case Management was not utilized.

2. No lead investigator assigned to the case resulting in the absence of an investigator in charge of the investigation.

3. Having a knowledgeable supervisor with a wealth of knowledge and different background techniques at the onset of the investigation would have been beneficial.

4. The investigation was carried out as a sudden death investigation: not a suspicious death or murder investigation.

5. The investigation should have been ruled as suspicious at the onset.

6. There was evidence that a sexual assault may have taken place. The investigation should have been investigated as Major Case and homicide until proven otherwise.

7. The identification of a suspect nor Person of Interest (POI), with more thorough investigation did not take place by the investigators. If this was treated as a suspicious death, there would have been more emphasis on possible foul play. There is no reason, with the number of bruises on A.B.'s body and injuries noted by investigators, that further follow-up was not completed.

8. The use of unconventional investigational techniques was not used, i.e. undercover operations/undercover cell mate.

9. The use of conventional investigative approaches (Cautioned Statement, Polygraph, or Alibi Statement) was not used.

10. No further investigation was completed with regard to what other circumstances or actions could have contributed to her death, such as how she came to be unconscious and if there were indicators of sexual assault.

**EVIDENCE AND INVESTIGATION:**

**Canvass:**

1. Request for more video surveillance from the location of residence was not requested to observe returning to the resident on March 29, 2016.

2. Video was available from a business located along the presumed route of travel for review, yet no officer report or notes were submitted, advising whether police had reviewed the video.

3. Video from another business located along the presumed route of travel was seized and not reviewed.

4. The review of video surveillance from a business located along the presumed route of travel should have included contacting the store to obtain a time stamp to assist in establishing valid timeline of the events.

**Scene:**

1. Forensic Identification Officer attended the scene, photographed and seized items prior to the investigators attending the scene. Items placed back in the "approximate positions where the exhibits had been found earlier and seized" to support completing a scale computerized reconstruction of the scene. The exhibit seizure was poorly executed. There was a lack of communication with a supervisor to provide guidance in this area of processing exhibits.

2. Seized items were sent to Property and Stores "pending the results of the Toxicology report and the need for further testing" which suggests that the decision whether to send these exhibits for forensic testing rested with the level of intoxication of the victim at the time of her death.

3. Multiple signs of recent injuries – while potentially non-contributing her death, attempts should still have been made to determine how A.B. obtained those injuries and would have assisted in determining if a sexual assault had occurred.

**Post-Mortem and Toxicology:**

1. Forensic Identification Officer attended the post-mortem examination, with no prior knowledge of the investigations. The Forensic Identification Officer did not mention any conversation with anyone from the investigation.

2. It appears the Forensic Identification Officer lacked the detail of the investigation that was required for the post-mortem examination. The pathologist was not apprised of key information such as the DNA Offender Hit Notification and the fact that the individual who was with A.B. prior to death admitted to having sexual intercourse with A.B. in the area where she was located.

3. No comment by the Forensic Pathologist that completed the post-mortem regarding the extensive fresh injuries on the victim. There were no comments regarding the anal tearing observed on A.B.

4. No notes or records of the Forensic Identification Officer or Forensic Pathologist discussing any of the findings of the post-mortem examination.

**Statements:**

1. Statements were not obtained from key persons involved in this incident.

2. Several witness statements were not obtained, including one of the last people to see her alive.

3. One witness statement that was done was only completed as a notebook statement and not included in the report.

4. Statements were not completed with all staff members at the location where she was residing. Each person had conversations with the last person who was with her before she died in the morning upon his arrival to the house as well as statements obtained with persons with him when he saw the news article about A.B. If a statement from him one of the staff members was obtained at the beginning of the investigation, he would have told then he last saw A.B. with the individual between 2330 hours and 2345 hours. He returned to the residence at approximately 0730 the next morning. If statements had been obtained from the staff, the level of intoxication, demeanor and appearance may have been documented.

5. Investigators did not interview her mother to obtain a greater understanding of her life.

6. There was no statement taken from an associate of the last person who was with A.B. during the original investigation. He left with him the morning after seeing the news article. What did they talk about? Was he with them for part of the night? When did he leave the location where he was residing and when did he meet up with them? He should have been considered as a suspect or a person of interest. The Blended Investigative Team (BIT) confirmed that he is deceased and as a result no interview conducted.

7. The last person who was with A.B. was interviewed as a witness but not a suspect. He should have been cautioned after he stated he had sexual intercourse with her at the scene. The witness statement should have ended and a caution should have been given to him. The Blended Investigative Team (BIT) was unable to conduct further follow-up with him as it was confirmed he is deceased.

8. It appears investigators did not examine this individual for injuries or marks which could have explained the DNA found under A.B.'s fingernails.

9. A witness observed a group of people walking in the direction of A.B. when he left the area. It appears no attempts were made to determine the identity of the persons observed drinking near the bridge/river on the night of A.B.'s death.

10. A witness observed a group of people walking in the direction of A.B. when he left the area, and no attempts were able to identify who they were.

## 4. Q.R.: Death Investigation Summary of Final Report

**Deceased:** Q.R.

**Reported Missing:** October 28, 2009

**Dispatch Date/Time:** November 10, 2009

**Incident Location:** 1186 Memorial Avenue, Thunder Bay, Ontario

**Cause and Manner of Death:** The original cause of death provided after the initial death investigation was asphyxiation due to or as the consequence of drowning, due to or as the consequence of associated with alcohol intoxication; manner of death undetermined. On June 28, 2016, the Verdict of a Coroner's Jury in relation to the Seven Youth Inquest concluded the cause of death was drowning with acute ethanol intoxication and that the manner of death was accident. This was unchanged following the reinvestigation.

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**REINVESTIGATION**

**All Existing Documents Reviewed by the Investigative Team:**

- Environmental Information – assessment of the weather conditions for the October 26 and 27, 2009. Investigator checked for water temperature but was advised that Environment Canada does not record water temperatures for the City of Thunder Bay.
- Original investigative files:
    - Audio/visual interviews
    - Coroner's Investigation Statement, Post-Mortem Report and Toxicology Report
    - The OPP inquest preparation files (part of Seven Youth Inquest) which include 241 files – audio/video interviews, written statements and other investigative documents.
    - 1433 pages of transcripts from the inquest that consisted of testimony pertaining to Q.R.'s death.
    - 38 individuals were interviewed during the Q.R. death investigation with numerous others spoken to.

**Scene re-investigation:**

- May 6, 2020, Lead Investigator and Forensic Identification officer attended Balmoral Street and William Street to initiate a scene re-examination. An Unmanned Aerial System (UAS) was used to obtain numerous photographs pertaining to the re-investigation and the general scene. An aerial grid was also captured as well as angled photographs of the scene.

**Medical Examinations and Independent Review:**

- Conducted by coroner and forensic pathologist members of the Investigative Resource Committee (IRC). In addition, an investigating coroner from the Baawaating Family Health Team, completed an independent review of all forensic files related to the death.
- The Peel Regional Police Forensic Identification Services completed an independent review of all forensic evidence.

**Reports, Recordings and evidence obtained and reviewed:**

- Thunder Bay Fire Rescue Master Incident Report
- Computer Aided Dispatch (CAD) report from TBPS RMS and audio recording for EMS
- Dennis Franklin Cromarty High School Transcripts
- Additional Property Located in TBPS Property and Stores (backpack and contents referred to in the OIPRD Broken Trust Report)
    - Following forensic investigation and interviews with Q.R's father, it was determined that backpack and contents there was no evidence linking it with Q.R.
- Polygraph examinations were conducted with specific main witnesses and persons of interested as deemed necessary. All examinations took place with the consent of the person being interviewed.

**INVESTIGATIVE ISSUES IDENTIFIED DURING REINVESTIGATION of ORIGINAL TBPS/CORONER INVESTIGATION:**

1. This investigation should have been treated as suspicious from the onset and Major Case Management should have been utilized.

2. The investigation into the death of Q.R. was deficient in several areas. Major Case Management was not part of the investigation which led to many important steps being incomplete.

3. No proper scene canvass or grid search was completed. A search of the entire area would have been helpful in determining if any evidence was present relating to the investigation Further Q.R.'s backpack, jacket and shoe were all unaccounted for.

4. The scene was released at 1730 hours, only two hours after the body of Q.R. was discovered. It appears the decision to release the scene was made by an Acting Patrol Sergeant without any direction from the Criminal Investigation Branch. Holding the scene would have allowed investigators to conduct a proper search of the area.

5. It does not appear the death of Q.R. was treated as suspicious. The death of a 17-year-old boy found in the McIntyre River should immediately prompt a thorough investigation. Further investigation should have been done to understand the reasons why Q.R. was in the water with such high levels of ethanol in his system. Q.R. was under the legal drinking age raising concern about how he accessed the alcohol, a contributing factor in his death.

6. A total of nine photographs were taken at the scene. This is troubling as additional photographs may have provided investigators additional information for the investigation. It was noted by officers on scene that the river edge appeared not to have been disturbed but further photographs of the river's edge ay have helped evaluate this. A total of 19 photographs were taken at the post-mortem examination. Again, additional photographs could help investigators determine the extent of Q.R.'s injuries.

7. Investigators failed to conduct a proper canvass at nearby houses and businesses. Potential witnesses may have been able to provide information to assist in the investigation. A canvass in 2020 revealed several video surveillance cameras located at businesses within the area. Any video surveillance footage was no longer available.

8. Investigators did not assign a crime analyst at the earliest stage of the investigation. Though this would not be normal practice in a non-suspicious sudden death investigation, the use of a crime analyst could assist in building a timeline and flowchart for the investigation. An analyst would also be able to assist in a missing person's investigation to create timelines prior to Q.R. having been found. The missing person investigation appears to have been mainly completed by the liaison officers and the search party that attended from Keewaywin First Nation.

9. Information was provided to the Criminal Investigation Branch (CIB) regarding an individual possibly being with Q.R. prior to his death. The CIB dismissed this theory and did not speak to this person until after Q.R. was located. Interviewing this person may have alerted investigators to key information and possibly to the riverbank much sooner.

10. A witness came forward regarding Q.R. possibly being held by drug dealers. It does not appear TBPS officers followed up with the information during the initial investigation. The witness was later interviewed by the OPP as part of the inquest preparation and the information was confirmed, directly by the witness, to be unfounded.

11. There was no consultation between investigators, the coroner or the pathologists. Although the cause of death was ultimately determined to be a drowning, investigators should have explored the circumstances surrounding how Q.R. got into the water. There should have been more concern regarding the fact that a 17-year-old drowned.

12. Working relationships among police services is becoming ever more important for proactive policing. In the case of a missing person investigation, information sharing is a vital component and could aid investigators with potential information or identify witnesses. Investigators requested assistance from Nishnawbe-Aski Police Service 12 days after Q.R. was reported missing.

13. A potential suspect told investigators he would be willing to take a Polygraph examination to prove his innocence. It does not appear this was explored by investigators. Removing him as a

potential suspect could have allowed investigators to concentrate on other persons of interest or investigative avenues.

14. It appears the investigator with the CIB and the Forensic Unit took minimal notes during the investigation and also played a minimal role. The lead investigator assigned to the case was not a member of the CIB.

15. It appears once the toxicology report came back the investigation ended. A decision was made by the CIB that no further action would be taken even though investigators had not determined how Q.R. ended up in the water. It is believed the toxicology report should have made investigators continue the investigation based on the fact that Q.R.'s drowning may have been due to his alcohol consumption, which he was not legally able to purchase. Further investigation on how he obtained the alcohol and proper charges should have been laid to after people who are considered "runners."

16. Several statements were not completed on audio and video. Notebook statements are completed to gain preliminary information at the scene or when someone is uncooperative. It appears very few statements were completed on audio and video that were pertinent to the investigation.

17. Q.R. appears to be missing a black backpack, a hoodie and a shoe. The person who was last known to be with him was arrested the same evening. He was reported to be drinking with Q.R. Further follow up questions should have been completed with officers who arrested him to determine what property he had with him, utterances he may have made, and a description of his appearance. As many years have passed since his arrest, officers would not be able to give such details such as this based on memory.

18. When a potential person of interest was interviewed at the Thunder Bay District Jail, he denied knowing Q.R., even after it was confirmed they were together October 26th. Later in the investigation, this person should have been cautioned as a suspect in the death of Q.R. He was the last person believed to be with Q.R. and denied knowing him. This would have made him a person of interest at the least.

19. Very few photographs were taken at the post-mortem examination It also does not appear any discussion regarding injuries to Q.R.'s head and face were explored nor was it documented.

20. The lead investigator attended DFC School to review video of Q.R. leaving the school. A copy of the video should have been requested for the investigation.

21. It was reported that Q.R. was at the Intercity Mall with an individual. Video surveillance should have been obtained at the earliest part of the investigation to assist in developing a timeline. The video could have showed investigators exactly what he was wearing and what items Q.R. had on his person. This would have helped investigators know who left with Q.R.

## 5. S.T.: Death Investigation Summary of Final Report

**Deceased:** S.T.

**Reported Missing:** February 08, 2011

**Body Discovered:** May 10, 2011

**Incident Location:** Kaministiquia River, approximately 600 meters east of the James Street Bridge, Thunder Bay, Ontario

**Cause and Manner of Death:** The initial cause of death (2011) was cold-water drowning and manner of death of accident. At the conclusion of the Coroner's Inquest (June 28, 2016) the Verdict of the Coroner's Jury concluded the cause of death was drowning with acute ethanol intoxication and manner of death undetermined. The cause and manner of death did not change as a result of the reinvestigation.

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**REINVESTIGATION**

**All Existing Documents Reviewed by the Investigative Team:**

- Environmental Information – assessment of the weather conditions from February 06, 2011 to February 13, 2011.
- Original investigative files:
    - Audio/visual interviews
    - Coroner's Investigation Statement, Post-Mortem Report and Toxicology Report
    - The OPP inquest preparation files (part of Seven Youth Inquest) which include 2868 files – audio/video interviews, written statements and other investigative documents.
    - 2315 pages of transcripts from the inquest that consisted of testimony pertaining to Jordan S.T.'s death.
    - 387 individuals were interviewed during the S.T. death investigation with numerous others spoken to.

**Scene re-investigation:**
April 02, 2020 and June 24, 2020, lead investigators and member of the TBPS Forensic Identification Unit initiated a scene re-examination. An Unmanned Aircraft Vehicle (UAV) was used to obtain an aerial grid and angled photographs of the scene. They mapped the evidence onto the aerial photos using the FARO 3D program.

**Medical Examinations and Independent Review:**

- Conducted by coroner and forensic pathologist members of the Investigative Resource Committee (IRC). An investigating coroner from the Baawaating Family Health Team also completed an independent review of all forensic files related to the S.T. death investigation.

**Reports, Recordings and evidence obtained and reviewed:**

- Thunder Bay Fire Rescue Master Incident Report
- 911 April 30, 2016 call when her body was discovered.
- Crime Stoppers tip.

**Reinvestigation:**

- Several individuals were interviewed during the reinvestigation – some were interviewed previously, many were not.
- Many interviews explored theories investigators learned about regarding how and/or why S.T. died.
- A financial grid search was completed.

**INVESTIGATIVE ISSUES IDENTIFIED DURING REINVESTIATION of ORIGINAL TBPS/CORONER INVESTIGATION:**

1. People who would have had direct knowledge of the drug death (re: mistaken identity theory) were not interviewed.

2. Investigative theories that surfaced during the original investigation were not thoroughly investigated.

3. Important interviews were conducted in the “back of a car” or in a person’s home, which is not best practice.

4. Investigators appeared closed minded and dictated interviews as opposed to gathering information.

5. Circumstances surrounding the disappearance of S.T. was immediately suspicious as he was last seen near his home.

6. Explore all possible scenarios as to why S.T. did not go home.

7. During the investigation, individuals with knowledge of S.T.’s lifestyle went unidentified and/or not interviewed.

8. The disappearance of S.T. should have been deemed suspicious.

9. Investigation significantly slowed after S.T. was found, after no obvious signs of trauma were identified on the body.

10. Further discussion between the investigator, coroner and pathologist should have taken place.

11. Further follow-up pertaining to S.T.'s possible drug debt(s) should have been pursued.

## 6. E.F.: Death Investigation Summary of Final Report

**Deceased:** E.F.

**Dispatch Date/Time:** April 30, 2016 at 1301 hours

**Incident Location:** Wooded area near the bike path off Brant Street, behind 198 County Boulevard, 125 feet from the Trans-Canada Highway East bound shoulder, Thunder Bay, Ontario

**Cause and Manner of Death:** Cause of death was hypothermia in a woman with ketoacidosis and acute ethanol intoxication and the manner of death was provided as undetermined. The cause and manner of death following the reinvestigation were the same as those provided following a review of the initial death investigation findings by the Regional Supervising Coroner and the examining Forensic Pathologist.

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**REINVESTIGATION**

**All Existing Documents Reviewed by the Investigative Team:**

- Environmental Information – assessment of the weather conditions for April 29 and 30, 2016
- Original investigative files:
    - Audio/visual interviews
    - Coroner's Investigation Statement, Post-Mortem Report and Toxicology Report
    - 29 individuals were interviewed during the E.F. death investigation with numerous others spoken to.

**Scene re-investigation:**

- On May 12, 2020 a full scene re-examination was completed with the assistance of the TBPS Forensic Identification Unit which included use of an Unmanned Aircraft System (UAS). Aerial grid and angled photographs were obtained of the scene.

**Medical Examinations and Independent Review:**

- Conducted by coroner and forensic pathologist members of the Investigative Resource Committee (IRC).
- In addition, an investigating coroner from the Baawaating Family Health Team, completed an independent review of all forensic file related to the E.F. death investigation.
- The Regional Supervising Coroner was consulted during this review.

**Reports, Recordings and evidence obtained and reviewed:**

- Thunder Bay Fire Rescue Master Incident Report
- 9-1-1 recording made on April 30, 2016 call when the body was discovered.
- Crime Stoppers tip.

**Reinvestigation:**

- Several individuals were interviewed during the reinvestigation – some were interviewed previously, many were not.
- All known family members and close friends were interviewed.
- A financial grid search was completed.

**INVESTIGATIVE ISSUES IDENTIFIED DURING REINVESTIGATION of ORIGINAL TBPS/CORONER INVESTIGATION:**

1. Failure to identify and properly secure short-lived evidence.

2. The scene was not properly searched by investigators.

3. The death should have been investigated as suspicious due to the fact an Indigenous female had been located deceased in a wooded area with her pants down. The investigation should have been investigated as a Major Case and treated as suspicious (homicide) until proven otherwise.

4. Officer did not take charge of the scene and did not track and take a scene attendance sheet.

5. Lack of oversight regarding:
    - Scene management;
    - Direction of investigation;
    - Status of file;
    - Supervision of file – Detective Sergeant – In charge of Reviewing Benchmark, assigning follow-up and final approval;
    - Lack of Victim/Family Liaison representative, communication with family during and after the investigation;
    - Family attended the scene with investigators and noted some items of interest; however, officers did not seize all the items. Specifically, a pair of sunglasses that the family felt may belong to an ex-boyfriend of E.F. Note: this person died in 2017; and
    - Failed to obtain victim history, background and creating a timeline of the victim before her death.
    - Failed to complete a thorough and transparent investigation:
        - Witnesses not interviewed – family, spouses, close friends, first responders;
        - Interviews did not follow best practices and guidelines i.e. audio video interviews, main witnesses interviewed separately;
        - Lack policy/procedure in evidence collection, tracking of evidence, processing evidence and maintaining storage of evidence;
        - No analysis completed on evidence; and

- Lacks request to obtain recordings for file and or requesting a hold before they are written over i.e. 9-1-1 recordings, GPS data on vehicles, CCIP queries/messages storage.

6. Missing detailed officers' notes.

7. Investigators did not conduct a neighbourhood canvass for witnesses.

8. Investigators failed to conduct a video canvass to locate or identify witnesses, obtain video surveillance CCTV footage.

9. Lead investigator was not at the scene when coroner attended.

10. Witnesses who did approach police were never interviewed by police.

11. No mention of any investigation into E.F.'s electronic communications.

12. Coroner took the lead at the scene to remove the body instead of police.

## 7. I.J.: Death Investigation Summary of Final Report

**Deceased:** I.J.

**Dispatch Date/Time:** March 21, 2017 at 1455 hours

**Incident Location:** Behind Canadian Tire located at 939 Fort William Road, Thunder Bay, Ontario

**Cause and Manner of Death:** Hypothermia and ethanol intoxication in a woman with left ankle fracture and the manner deemed to be accident. These findings were unchanged from the initial death investigation.

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**REINVESTIGATION**

**All Existing Documents Reviewed by the Investigative Team:**

- Environmental Information – assessment of the weather conditions for March 20 and 21, 2017
- Original investigative files
- Audio/visual interviews
- Thunder Bay Fire Rescue Master Incident Report
- 9-1-1 recording from when I.J. was found
- All exhibits collected during the investigation (and those omitted)
- Coroner's Investigation Statement, Post-Mortem Report and Toxicology Report
- 12 individuals were interviewed during the I.J. death investigation with numerous others spoken to.

**Scene re-investigation:**

- On March 26, 2020 a full scene re-examination was completed with the assistance of the TBPS Forensic Identification Unit with aerial photographs provided by the TBPS Traffic Unit.

**Medical Examinations and Independent Review:**

- Conducted by coroner and forensic pathologist members of the Investigative Resource Committee (IRC).
- In addition to the Coroner's Investigation Statement, Post-Mortem Report and Toxicology Report, I.J's medical history/reports were obtained for review.
- An investigating coroner from the Baawaating Family Health Team completed an independent review of all forensic files related to the I.J. death investigation.
- Peel Regional Police Forensic Identification Services (FIS) completed an independent review of all forensic evidence in this investigation.

**INVESTIGATIVE ISSUES IDENTIFIED DURING TBPS/ORIGINAL CORONER INVESTIGATION**

1. The assessment of the scene: When I.J. was located the scene should have been ruled as that of a suspicious death. There was evidence that would have led investigators to believe the death was suspicious:
    - left shoe was on and her right shoe was located approximately one metre from the body;
    - her full upper denture plate was located on the ground with blood;
    - a change purse was open with numerous coins on the ground;
    - a clump of hair gripped in her left hand; and
    - the belt and sunglasses captured in the scene photos do not appear on the exhibit list.

2. A lead investigator was not identified. It is critical that at least one investigator (Lead) be aware of all the information gathered in the initial stages of a suspicious death investigation.

3. Major Case Management (MCM) was not utilized. The MCM structure, consisting of a Primary Investigator, File Coordinator and Team Lead, ought to have been utilized to investigate the suspicious death.

4. Minimal processing of the crime scene. An individual of possible interest attended the crime scene and took evidence that was not seized by investigators.

5. A video canvass was not completed in this investigation and as a result, investigators lost valuable video surveillance evidence. The retention period for video surveillance footage was typically short-term and therefore, ought to be addressed at the onset of an investigation.

6. Intercity Mall video surveillance footage was initially reviewed by mall security to select the relevant timeframe to provide to investigators. Video surveillance should have been reviewed by investigators and not a security guard. Investigators should have determined the time period of interest and requested the footage accordingly.

7. The Liquor Control Board of Ontario advised that they were unable to download the video as it took too much space. In this scenario, investigators ought to have provided a storage device for the video download.

8. All witness statements should have been audio or video recorded.

9. Medical records were not obtained for I.J. arising from the Mental Health Act assessment on March 19, 2017. Review of these records could have helped to clarify pos- mortem findings (i.e. bruising, ankle fracture and additional contusions).

10. A neighbourhood canvass should have been completed.

11. An overall lack of oversight regarding:
    - Crime scene management;
    - Direction of investigation; and
    - Supervision of File – Detective Sergeant – in charge of Reviewing Benchmark, assigning follow-up and final approval.

12. Items seized at the scene were never considered to be sent for analysis.

## 8. G.H.: Death Investigation Summary of Final Report

**Deceased:** G.H.

**Dispatch Date/Time:** March 25, 2015 at 0905 hours

**Incident Location:** Junot Park walking path located north of the Junot Avenue Fire Station, Thunder Bay, Ontario

**Cause and Manner of Death:** Cause of death hypothermia with acute alcohol intoxication; manner of death accident. These findings were unchanged from the initial death investigation.

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**REINVESTIGATION**

**All Existing Documents Reviewed by the Investigative Team:**

- Environmental Information – assessment of the weather conditions for March 24 and 25, 2015
- Original investigative files:
    - Audio/visual interviews
    - Coroner's Investigation Statement, Post-Mortem Report and Toxicology Report
    - 15 individuals were interviewed during the G.H. death investigation with numerous others spoken to.

**Scene re-investigation:**

- January 29, 2020 a full scene re-examination at Junot Park was completed with the assistance of the TBPS Forensic Identification Unit. A subsequent re-examination at Junot Park was conducted on March 23, 2020 with the use of TBPS Unmanned Aircraft System to obtain aerial photographs of where G.H. had been located deceased. The Faro 3-D software was also applied.

**Medical Examinations and Independent Review:**

- Conducted by coroner and forensic pathologist members of the Investigative Resource Committee (IRC).
- In addition, an investigating coroner from the Baawaating Family Health Team, completed an independent review of all forensic file related to the G.H. death investigation.
- Peel Regional Police Forensic Identification Services completed an independent review of all forensic evidence in this investigation.

**Reports, Recordings and evidence obtained and reviewed:**

- 911 recordings
- EMS dispatch report
- Further interviews were conducted.
- A financial grid search was completed at the RBC, TD, CIBC, BMO and BNS.

**INVESTIGATIVE ISSUES IDENTIFIED DURING TBPS/ORIGINAL CORONER INVESTIGATION**

1. Major Case Management was not utilized

2. Failure to preserve and seize short-lived evidence resulting in lost investigative opportunities.

3. The scene was not properly searched by investigators.

4. The crime scene was not properly processed, i.e. photographs of the footprints in the snow near the body. Assumption that footprints near the body were made by fire and paramedics – did not preserve and compare for elimination.

5. Assumptions made by the police and the coroner at the onset of the investigation regarding the cause of death.

6. No criminal investigators attended the scene of the body and thus were not in a position to drive the investigation.

7. No clear indication who was in charge of the investigation.

8. Investigators did not seal the body pouch, nor did the investigator accompany the body when it was transported from the scene to the post-mortem and investigators lost continuity of the body.

9. Lack of oversight regarding:
- Crime Scene Management;
- Direction of Investigation;
- Supervision of File – Detective Sergeant – In charge of Reviewing Benchmark, assigning follow up and final approval.

10. No accounting of the footprints tracked back to the bush which officers “felt” were the cause of the minor abrasions to the body.

11. No mention of foot trail from bushes.

12. Injuries originally noted as consistent with a fall, but the only blood observed in snow was from droplets.

13. No indication that the blood samples collected from the scene were analyzed and compared to the G.H.’s blood.

14. No exhibits or evidence was sent for forensic analysis including blood that was seized at the scene.

15. During the post-mortem, a can of Old Milwaukee Ice was located in the front waistband of G.H.'s clothing. The beer can was photographed and said to be seized. There is no report if and where the beer can was lodged, if it was swabbed and if it was ultimately destroyed.

16. Lacks thorough and transparent investigation:
- Interviews did not follow best practices and guidelines i.e. audio/video interviews; having main witnesses interviewed separately; and
- Some witnesses not interviewed.

17. Only one person was interviewed, and it took place in the back of a car in the company of another person who was also present with G.H. on the night he died. This interview was not conducted under caution.

18. A number of people known to be with G.H. shortly before his death were not interviewed.

19. An individual was not interviewed following her text messages she reported to police despite supplying the number from where the texts originated.

20. No first responders interviewed to determine if they had any additional information to assist investigators.

21. Investigators did not participate in controlling the scene, interpreting the scene, discussing possibilities with the coroner, directing the investigation, directing the forensic officer, determining when the body was to be moved, nor did they attend the post-mortem.

22. A key witness was not asked during the interview about any injuries G.H. may have suffered, how they occurred, or any details about passerby he interacted with.

*23. The initial 9-1-1 call in relation to G.H. acting "erratically" in the park was never followed up on.

24. TBPS initial assumption was a male died as a result of hypothermia and death was accidental.

25. Limited dialogue between the investigators and the forensic identification officer.

26. Limited interaction between the investigator, pathologist and coroner.

27. Investigators should have considered if the injuries could have rendered a deceased person unconscious.

*NOTE: At the time of death, despite the fact a call was made for assistance and not fulfilled regarding G.H.'s well-being, Special Investigations Unit (SIU) was not contacted.
The Investigative Lead brough this to the EGC's attention and it was agreed that the matter should be referred to the SIU for consideration.

On January 26, 2022, the SIU confirmed that they would be invoking their mandate regarding the G.H. death investigation and the actions/non-actions by the TBPS. The SIU confirmed that they will be publicly announcing this via news release, which they did on January 28, 2022.

## 9. O.P.: Death Investigation Summary of Final Report

**Deceased:** O.P.

**Reported Missing:** Friday, September 23, 2005 – 2215 hours

**Body Discovered:** Monday, September 26, 2005 - 1920 hours

**Incident Location:** McIntyre River, approximately 210 feet East of Russell Street, Thunder Bay, Ontario

**Cause and Manner of Death:** After the initial death investigation the cause of death was determined to be drowning with a contributing factor of alcohol intoxication. The manner of death was concluded to be accident. The Verdict of the Coroner's Jury in relation to the Seven Youth Inquest concluded that O.P.'s cause of death was drowning with a contributing factor of alcohol intoxication and that the manner of death was accident. The cause and manner of death were not changed after the re-investigation.

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**REINVESTIGATION**

**All Existing Documents Reviewed by the Investigative Team:**

- Environmental Information – assessment of the weather conditions for September 22 to September 25, 2005
- Original investigative files:
    - Audio/visual interviews
    - Coroner's Investigation Statement, Post-Mortem Report and Toxicology Report
    - The Ontario Provincial Police inquest preparation files pertaining to O.P.'s death were thoroughly reviewed. 502 files were examined which consisted of audio/video interviews, written statements as well as other investigative documents.
    - 1516 pages of transcripts from the 2015 Coroner's Inquest (Seven Youth Inquest) were reviewed. The review consisted of testimony pertaining to O.P.'s death.
    - 84 individuals were formally interviewed as part of the O.P. death investigation, numerous others were spoken to.

**Scene re-investigation:**

- May 6, 2020 a full scene re-examination was completed by the reinvestigation team with the assistance of the TBPS Forensic Identification Unit. They utilized an Unmanned Aircraft System to obtain aerial photographs of the area and obtain an aerial grid and angled photographs. Further work was done in August by applying the FARO 3D software program to create a 3D representation of the area where O.P. was located.

**Medical Examinations and Independent Review:**

- Conducted by coroner and forensic pathologist members of the Investigative Resource Committee (IRC).
- In addition, an investigating coroner from the Baawaating Family Health Team, completed an independent review of all forensic file related to the O.P. death investigation.

**Reports, Recordings and evidence obtained and reviewed:**

- Searches were conducted of the TBPS Records Management System (RMS) for phone records associated with O.P.
- A financial grid search was conducted at five of the largest Canadian financial institutions – RBC, TD, CIBC, BMO and BNS.
- Several interviews were conducted.

**INVESTIGATIVE ISSUES IDENTIFIED DURING TBPS/ORIGINAL CORONER INVESTIGATION**

1. There appears to have been no police activity from when O.P. was reported missing on September 23, 2005 at 2215 hours to when Detective Constable GIBSON received the missing person report on September 24, 2005 at 2045 hours, approximately 22.5 hours later.

2. The missing person report contained incorrect information. It indicated O.P. was last seen on September 23, 2005 at 1730 hours, the correct date was September 22, 2005. It also indicated O.P. was missing from a foster home which was also incorrect.

3. There were no attempts at obtaining video surveillance from Intercity Shopping Centre, The Beer Store or from the LCBO which would have corroborated the witness statements and assisted in identifying who purchased the liquor for the youths who were all underage.

4. Interviews were not conducted following the discovery of O.P.

5. The position of O.P.'s hand indicated he may have been alive when he entered the water. There was no follow-up completed with Doctor JANI until the inquest preparation.

6. There appears to have been no discussion between the investigators, the coroner and the pathologist pertaining to injuries, specifically the "cerebral edema" which was noted in the autopsy findings.

7. There appears to have been no follow-up pertaining to the red woman's underwear located in the rear pocket of O.P.'s pants during the post-mortem examination.

8. There are no reports on file to suggest that any forensic testing had been completed on the clothing before being released to O.P.'s family.

9. There appears to have been no investigation into why O.P.'s pants and zipper were undone.

10. There appears to have been no investigation into why O.P. was not wearing a shirt or shoe on his right foot.

11. There was no Crime Scene Continuity Register located within the file.

12. O.P. was removed from the water and placed on shore beside a set of bushes. It would have been ideal for the body to have been placed onto a clean surface, such as a tarp or cadaver pouch to prevent evidence transfer between the body and the scene.

## Broken Trust Recommendation#3: The multi-discipline investigative team should establish a protocol for determining whether other TBPS sudden death investigations should be reinvestigated.

In the Terms of Reference, one of the roles of the Blended Investigative Team (BIT) was to: "Share with the Executive Governance Committee additional cases identified during the reinvestigation that, in the view of the team lead, would warrant further investigation." The BIT developed a process to identify and engage with the combined membership of the Investigative Resource Committee (IRC) of experienced death investigators (law enforcement, coroners, forensic pathologists, legal counsel and forensic sciences professionals) to exchange professional opinions and recommendations whether cases warrant further investigation.

**APPROACH and RECOMMENDATION:**

The TBPS RMS review process of sudden death cases primarily focused on calendar years 2010-2017 with a limited review of cases between 2018-2020 and 2000-2009. The decision to start with 2010-2017 for the case review timeframe was to align this process with the OIPRD Broken Trust Report timeframe and to include additional years in the RMS search when BIT timelines and resources permitted additional reviews.

Analysts entered the TBPS RMS and completed an initial query based on search types for the timeframes of 2010-2017, as well as OCC records for Indigenous deaths between 2003-2009, which were queried individually. These processes generated a total of 1,771 TBPS occurrences that were then reviewed by BIT members with TBPS RMS access.

- 229 occurrences were identified and sent to experienced BIT sworn death investigators working with different law enforcement agencies outside of the TBPS.
- Sworn officers consisted of male and female members, as well as Indigenous and non-Indigenous experienced homicide and sudden death investigators, including members from two First Nations Police Services.

BIT death investigators reviewed cases of investigative concern and recommended that **17 cases** for further discussion with experienced death investigators in forensic pathology, coroner and criminal law prosecutions for their opinions and collective decisions regarding if the case should be recommended to the EGC for further consideration.

Following case conferences on these cases, it was determined that:

- 14 cases warrant further police led investigation;
- Two cases should be considered for a coroner led review as it was determined these cases may support public safety interests and further investigative follow-up; and
- One case was referred to the Special Investigations Unit.

The EGC has submitted the 16 cases to the Ministry of Attorney General for further review. Each of the families of the deceased persons will be informed that concerns were identified with the death investigation and the investigation was submitted to the Ministry of the Attorney General.

**Broken Trust Recommendation#4: The multi-discipline investigative team should assess whether the death of Stacy DeBungee should be reinvestigated, based on my Investigative Report and 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.**

In response to Recommendation #4, the EGC, Blended Investigative Team and Investigative Resource Team all agreed that the investigation of Stacy DeBungee's death should be completed separately from the reinvestigation of the nine deaths identified in Recommendation #1. Having the TBPS participate in this investigation presented a potential conflict of interest having three officers facing Police Services Act proceedings relating to this case.

The Ministry of the Attorney General engaged the OPP to conduct the reinvestigation into the death of Stacy DeBungee. The EGC was informed that the OPP assigned a Detective Inspector to lead the Major Case Management of this case.