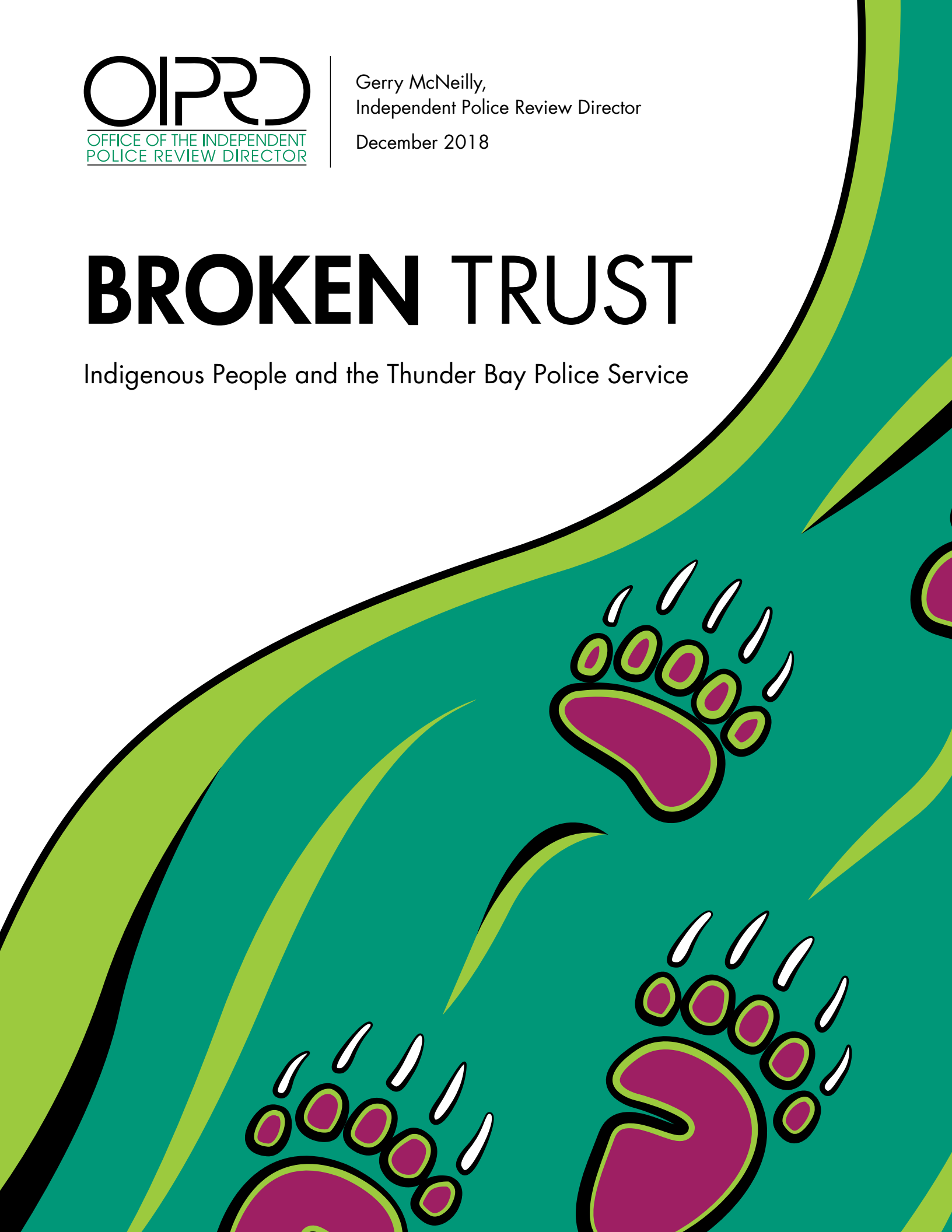


# BROKEN TRUST

Indigenous People and the Thunder Bay Police Service





This systemic review involves the Thunder Bay Police Service and events that occurred in Thunder Bay. The OIPRD respectfully acknowledges that Thunder Bay is located on the traditional lands of the Fort William First Nation within the Robinson Superior Treaty, and is the traditional territory of the Anishnaabeg and the Métis.

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# EXECUTIVE SUMMARY



In the early 1990s, Indigenous communities in and around Thunder Bay raised concerns about the quality of Thunder Bay Police Service (TBPS) investigations into the deaths of Indigenous people. A “Grassroots Committee on Native Unsolved Murders” identified more than 30 suspicious deaths of Indigenous people where there were allegations that TBPS did not conduct thorough investigations.

The committee circulated a petition requesting a federal inquiry be established to look into the circumstances of “18 unsolved deaths of Aboriginal people here.” Thunder Bay Police Service denied allegations of differential treatment in investigating Indigenous deaths. No inquiry was ever held.

As Ontario’s Independent Police Review Director, I became aware of the strained relations between TBPS and Indigenous people who live in or travel to Thunder Bay from northern Indigenous communities for school, jobs or services. I raised the issue with the police chief on a number of occasions, but remained unconvinced that TBPS’s responses improved the relationship. In March 2016, my office, the Office of the Independent Police Review Director (OIPRD), received complaints about the TBPS investigation into the 2015 death of an Indigenous man, Stacy DeBungee. Indigenous leaders and community members told me that TBPS investigations of Indigenous deaths and other interactions with police devalued Indigenous lives, reflected differential treatment and were based on racist attitudes and stereotypical preconceptions about Indigenous people.

On November 3, 2016, I initiated this systemic review to investigate and respond to these concerns. That the questions raised by Indigenous people in 1993 remained as valid as they did some 25 years ago, was deeply troubling, and demanded an urgent and comprehensive response.

The Police Services Act gives me the authority to examine and review issues of a systemic nature, and make recommendations to police chiefs, police services boards, the Attorney General, the Minister of Community Safety and Correctional Services and any other body. A systemic review is designed to identify and address larger issues of systemic importance, rather than find individual officer misconduct.

My office examined a total of 37 TBPS investigations involving sudden deaths going back to 2009, including cases we selected randomly or based on specific criteria. My primary focus was on the investigations of Indigenous deaths. My review also examined the cases that were the subject of the Coroner’s Inquest into the Deaths of Seven First Nations Youths and cases within the mandate of the National Inquiry into Missing and Murdered Indigenous Women and Girls.

My investigators interviewed 36 current and former TBPS officers and civilians on issues related to my systemic review. We also spoke with the Chief Coroner for Ontario, the Chief Forensic Pathologist, Nishnawbe-Aski Police Service, Anishinabek Police Service, York Regional Police investigators, Crown counsel in Thunder Bay, as well as other participants in the criminal justice system.

In addition to the case files, we requested and received existing TBPS policies and procedures for missing persons and death investigations, along with details of training provided to officers related to investigations. We received submissions from TBPS and from other interested stakeholders. This review considered a number of prior reports related to this topic and the recommendations contained in those reports.

The systemic review team and I collectively visited Thunder Bay more than two dozen times and had over 80 meetings with Indigenous leaders and community members, Indigenous organizations, community organizations and service providers, and individual members of the public. As part of our engagement process we also held a public meeting in Thunder Bay.

The first chapter of my report describes how this review came about, my terms of reference and, in general terms, how it was conducted.

If we are to understand the broken relationship between Indigenous people and police, we must first understand the history and impact of colonization on Indigenous people. Much of the suspicion and distrust that Indigenous people feel toward police is rooted in a history of colonial policies. Police were used to facilitate and carry out such policies. Chapter 2 aims to provide this much needed context.

Chapter 3 describes in detail our extensive community engagement. My review team heard a disturbing pattern of negative and discriminatory interactions between TBPS officers and Indigenous people. These

encounters ranged from allegations of serious assaults to insensitive or unprofessional behaviour. We heard both from individuals who were the subject of these interactions, and persons who witnessed them. The witnesses to these events were both Indigenous and non-Indigenous. We heard about the need for accountability, ongoing Indigenous cultural competency training and effective community policing.

Overall, our meetings revealed nothing short of a crisis of trust afflicting the relationship between Indigenous people and TBPS. This crisis of trust was palpable at most of our meetings, whether the participants were youth, Elders, service providers, professionals or Indigenous leaders.

Chapter 4 outlines the submissions sent to us by community organizations. Chapter 5 deals with relevant recommendations from previous reports on racism or policing.

As part of this systemic review, the OIPRD received written submissions from TBPS, in which the service pointed out several challenges including lack of resources, geographic barriers and the negative public perception that overshadow the work being done by its officers. The submissions also highlighted more than 30 initiatives TBPS has undertaken to help build better relationships with Indigenous people. TBPS's submissions are summarized in Chapter 6 of my report.

During my review, my team and I met with TBPS's senior management on several occasions. There were a number of systemic concerns we identified, particularly in relation to investigations of Indigenous sudden deaths that could

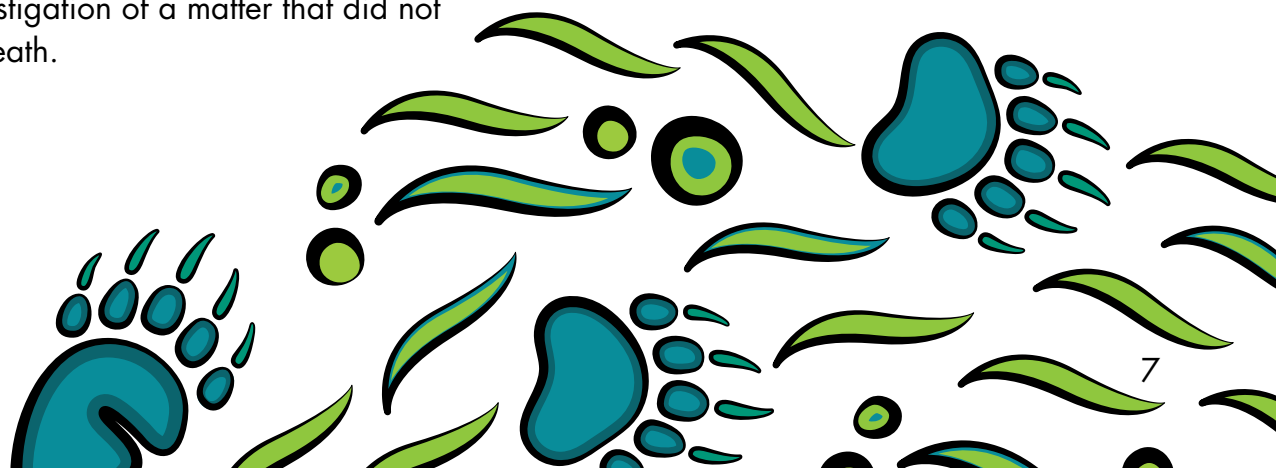
not await completion and release of my report. Similarly, we met with the Chief Coroner for Ontario to discuss systemic concerns we identified pertaining to the relationship between investigators, coroners and pathologists that could also not await the completion and release of my report. TBPS and the Chief Coroner advised us of initiatives undertaken, including new initiatives begun during my review, to attempt to respond to these concerns. I discuss these initiatives throughout the report.

I also acknowledge that TBPS has taken steps both before and during the systemic review to address concerns raised more generally about its relationship with Indigenous communities. I think it is important, especially in the context of a report which at times sharply critiques the work of TBPS, to also acknowledge and support positive initiatives which, in my view, may enhance the quality of policing in Thunder Bay and the relationship of the service to Indigenous people, especially when coupled with the recommendations made in this report. Some of the OIPRD's most important work during this review involved an independent examination of specific investigative files pertaining to Indigenous people. This allowed us to identify systemic failings. Our primary focus was on the investigations of Indigenous deaths, particularly sudden deaths. However, we also examined several non-Indigenous death investigations, as well as one investigation of a matter that did not involve a death.

Chapter 7 presents 11 of the 37 TBPS cases in which we conducted a detailed examination of the TBPS investigative file, as well as related documents. Our review exposed significant deficiencies in what TBPS records or maintains in its investigative files. OIPRD investigators conducted interviews with officers involved in a number of the cases we examined. In some instances officers provided information not available in the police investigative file.

We were also dealing with cases that were before the courts. Our reviews were limited for those cases in order to not prejudice ongoing proceedings. We also conducted a paper review of some of the identified Missing and Murdered Indigenous Women and Girls cases, recognizing that some of the older files had limited documents available.

In Chapters 8, 9 and 10, I outline my findings and recommendations. Chapter eight deals with TBPS sudden death and other investigations, the Criminal Investigations Branch and other TBPS operational areas and the relationships between TBPS and the coroner's and pathologist's offices. Chapter nine looks at racism and TBPS and Chapter 10 has recommendations for implementing my recommendations.



# Key Findings and Recommendations

Some of my key findings and recommendations include the following:

## Thunder Bay Police Service Investigations and Operations

The inadequacy of TBPS sudden death investigations the OIPRD reviewed was so problematic that at least nine of these cases should be reinvestigated. Based on the lack of quality of the initial investigations, I cannot be confident that they have been accurately concluded or categorized.

A number of TBPS investigators involved in these investigations lacked the expertise and experience to conduct sudden death or homicide investigations.

Investigators frequently misunderstood when matters should be investigated under the Major Case Management system, and failed to connect the autopsy report to their own investigations, failed to even find out the autopsy results or failed to understand the significance or lack of significance of the autopsy findings. On a number of occasions, attending forensic identification officers did not fulfill basic requirements.

Investigators failed to know what was in their own investigative file, including supplementary occurrence reports filed by uniform patrol officers. Inadequate supervision resulted in many shortcomings identified in the investigative files we reviewed.

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

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

Information sharing between TBPS and other police services continues to be uneven and unsatisfactory and results in policing "silos."

I found serious issues with the relationship between the police and the coroners, including lack of coordination, delegation and information sharing. 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.

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.

I also found that while there is strong support in the community for the Aboriginal Liaison Unit, almost everyone we spoke to told us two officers were insufficient. Many considered it tokenism. As explained in my recommendations, I contemplate an enhanced and expanded role with this unit.



## Thunder Bay Police Service and Racism

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

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.

My finding that investigations were affected by racial discrimination does not represent a determination that all TBPS officers engaged in intentional racism. However, overall I find systemic racism exists in TBPS at an institutional level.



## Recommendations Regarding 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.
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 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.

## Recommendations Regarding TBPS Investigators and the Criminal Investigations Branch

6. TBPS should immediately ensure sufficient staffing in its General Investigation Unit in the Criminal Investigations Branch. Adequate resources must be made available to enable this recommendation to be implemented on an urgent basis.
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.
8. TBPS should provide officers, who have taken the appropriate training with opportunities to be assigned to work with Criminal Investigations Branch and the Major Crimes Unit investigators to gain experience.
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, 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.**
- 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.**

## **Recommendations Regarding 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.**
- 16. TBPS should increase the number of officers in the Aboriginal Liaison Unit by at least three additional officers.**
- 17. With Indigenous engagement and advice, TBPS should take measures to acknowledge Indigenous culture inside headquarters or immediately outside it.**
- 18. Thunder Bay Police Service should make wearing name tags on the front of their uniforms mandatory for all officers in the service.**
- 19. TBPS should implement the use of in-car cameras and body-worn cameras.**
- 20. TBPS should, through policy, impose and reinforce a positive duty on all officer to disclose potential evidence of police misconduct.**

## Recommendations Regarding Missing Persons Cases

21. I urge the Ontario government to bring into force Schedule 7, the Missing Persons Act, 2018, as soon as possible.
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.
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 Toronto Police Service's missing persons investigations due to be released in April 2020.

## Recommendations Regarding 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.



## Recommendations Regarding 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.
- 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.

## Recommendations Regarding 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 form and content of these acknowledgements. This would be an important step in TBPS advancing reconciliation with Indigenous people.
- 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.
- 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.

## Recommendations Regarding Racism in TBPS Policing – Training

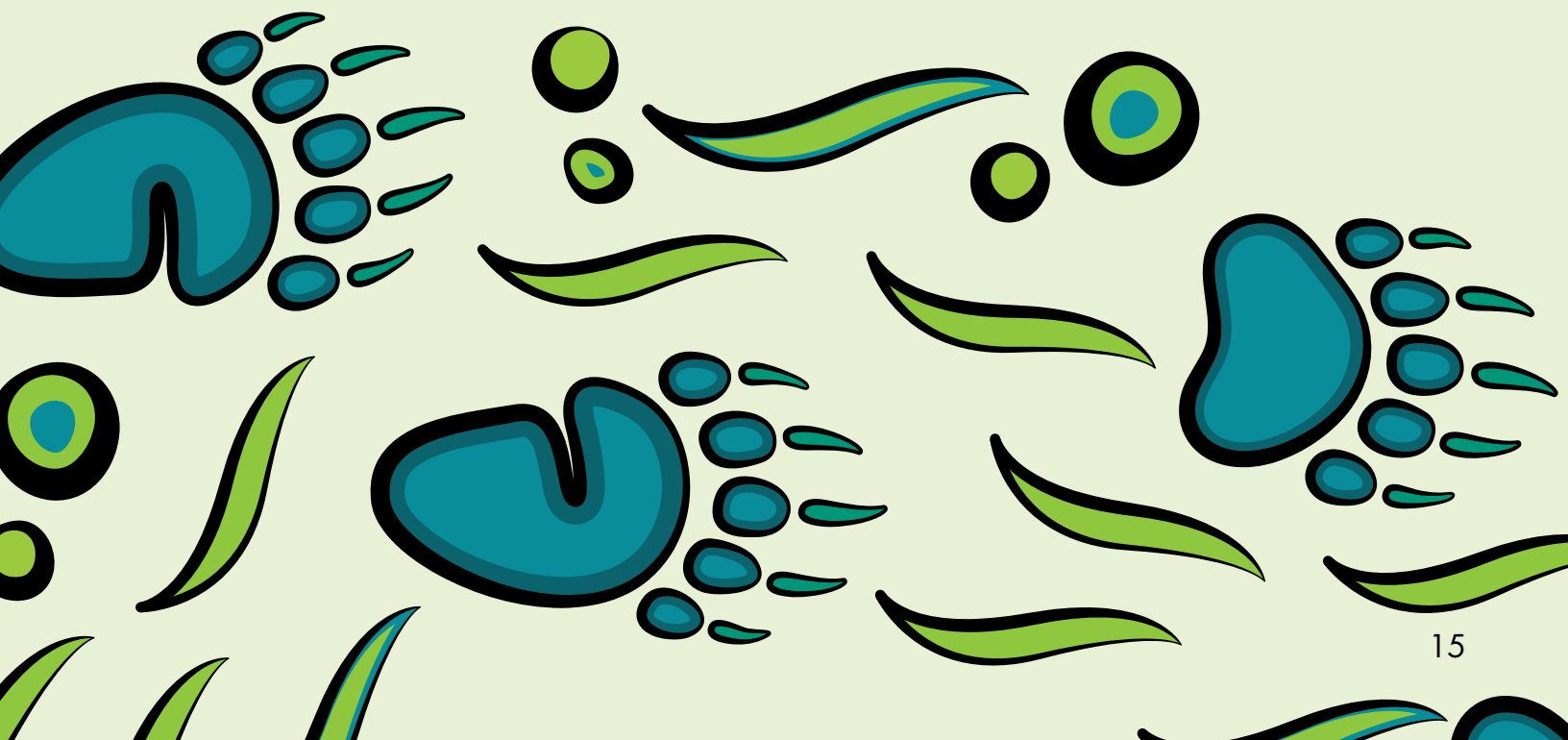
- 36. TBPS should work with training experts, Indigenous leaders, Elders and the Indigenous Justice Division of the Ministry of the Attorney General to design and implement mandatory Indigenous cultural competency and anti-racism training for all TBPS officers and employees, that:**
  - a. Is ongoing 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
  - 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.
- 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.**
- 38. TBPS leadership should provide greater support for voluntarism by attending relevant sporting or community events.**
- 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

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

## Recommendations for Implementation of Recommendations

43. TBPS 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.
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.



# Conclusion

I am indebted to those community members and organizations who have shared their views freely as to how TBPS 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, Thunder Bay Police Service and the broader community it is responsible for serving.



# CHAPTER 1: INTRODUCTION



In the early 1990s, Indigenous communities in and around Thunder Bay raised concerns about the quality of Thunder Bay Police Service (TBPS) investigations into the deaths of Indigenous people. A "Grassroots Committee on Native Unsolved Murders" identified more than 30 suspicious deaths of Indigenous people where there were allegations that TBPS did not conduct thorough investigations.

In 1993, the committee circulated a 3,000-signature petition requesting that a federal inquiry be established to look into the circumstances of "18 unsolved deaths of Aboriginal people here." Phillip Edwards, a member of the Thunder Bay Police Services Board (TBPSB), stated that "our lives as Natives are worth as much as anyone's life."<sup>1</sup>

Thunder Bay Police Service denied allegations of differential treatment in investigating Indigenous deaths. No inquiry was ever held.

When the Office of the Independent Police Review Director (OIPRD) opened its offices in 2009, I soon became aware of the strained relations between TBPS and Indigenous people who live in Thunder Bay or travel to Thunder Bay from northern Indigenous communities for school employment or services. On a number of occasions, I raised the issue of police-Indigenous relations with then police chief J.P. Levesque. He committed to improving the relationship between TBPS and Indigenous communities. In 2013, I convened a joint meeting with TBPS, the Deputy Grand Chief of Nishnawbe Aski Nation, the Executive Director of Nishnawbe-Aski Legal Services Corporation, a representative from Kinna-aweya Legal Clinic

and the Acting Chief of Nishnawbe-Aski Police Service, in order to help facilitate an ongoing relationship. As far as I am aware, the meetings did not continue. TBPS also undertook some other initiatives to address this issue. However, I was unconvinced that the relationship between TBPS and Indigenous communities improved appreciably.

Over the years, the OIPRD has received complaints about Thunder Bay police officers, alleging misuse of force, neglect of duty, inadequate investigations and differential treatment regarding Indigenous people. Some of these complaints were withdrawn when they were referred back to the police service for investigation. In his Report of the Independent Police Oversight Review, Justice Michael Tulloch recommended, with the OIPRD's support, that the Police Services Act and related regulations change so that the OIPRD would be able to retain most investigations of public complaints, rather than refer many of them back to the affected police service. The OIPRD refers most complaints back to police services because the agency does not have the resources to investigate all complaints. Justice Tulloch and I both recognized that referring public complaints back to the police undermined public confidence in the process.

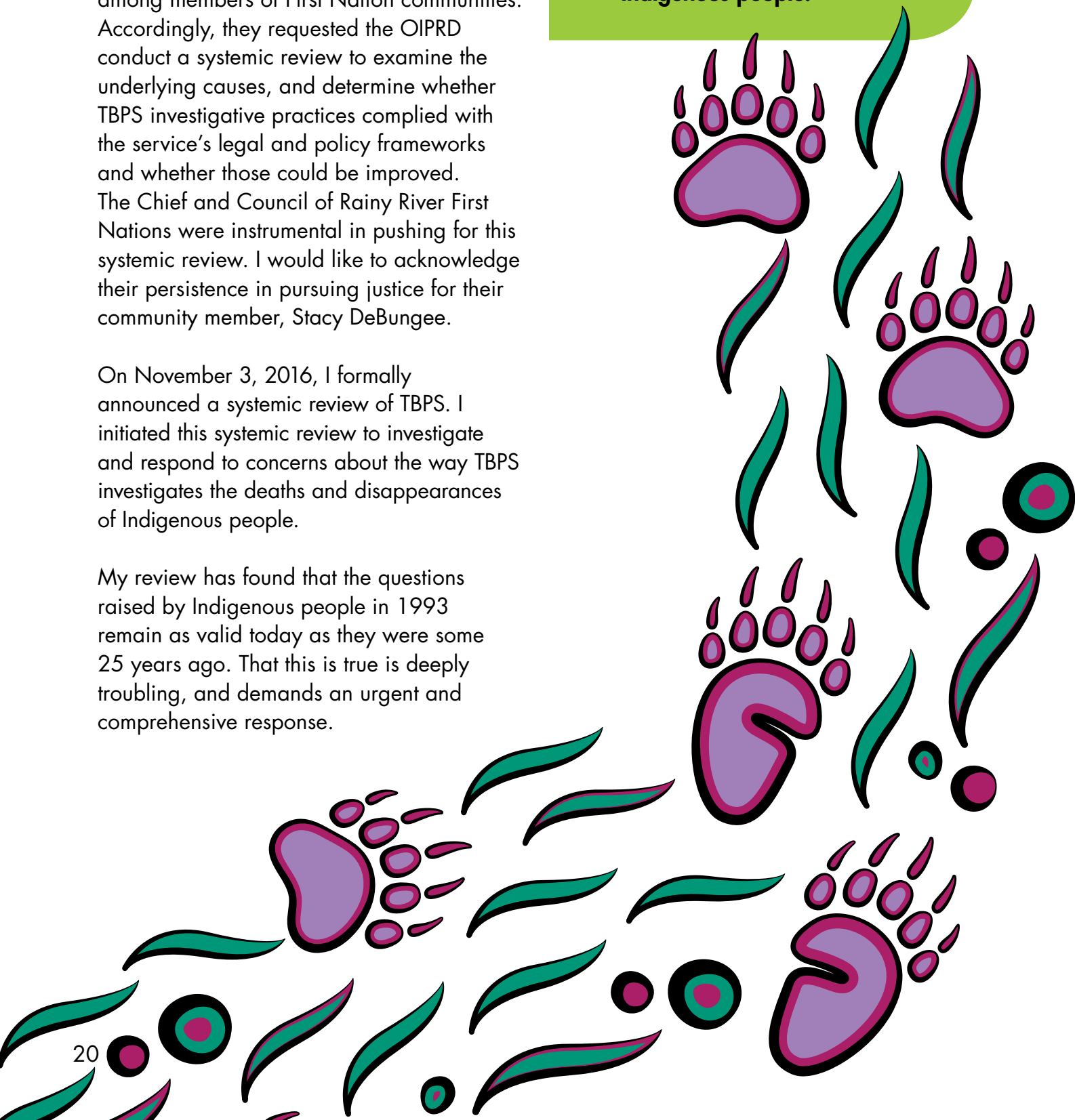
I have also heard from people who have chosen not to initiate complaints against the police despite concerns about how police dealt with them. I am aware that some Indigenous people distrust the OIPRD in the same way they distrust police. I acknowledge that there are good reasons for this lack of trust. All of these circumstances raised concerns for me.

In March 2016, the OIPRD received two complaints about the conduct of officers who were assigned to investigate the 2015 death of an Indigenous man, Stacy DeBungee. In addition to these conduct complaints, the complainants, from Rainy River First Nations said there is a “crisis of confidence” in TBPS among members of First Nation communities. Accordingly, they requested the OIPRD conduct a systemic review to examine the underlying causes, and determine whether TBPS investigative practices complied with the service’s legal and policy frameworks and whether those could be improved. The Chief and Council of Rainy River First Nations were instrumental in pushing for this systemic review. I would like to acknowledge their persistence in pursuing justice for their community member, Stacy DeBungee.

On November 3, 2016, I formally announced a systemic review of TBPS. I initiated this systemic review to investigate and respond to concerns about the way TBPS investigates the deaths and disappearances of Indigenous people.

My review has found that the questions raised by Indigenous people in 1993 remain as valid today as they were some 25 years ago. That this is true is deeply troubling, and demands an urgent and comprehensive response.

**I initiated this systemic review to investigate and respond to concerns about the way TBPS investigates the deaths and disappearances of Indigenous people.**



# The City of Thunder Bay

Thunder Bay sits on the northwest shore of Lake Superior. The city looks out at the Sibley Peninsula, where “Nanabijou,” the Sleeping Giant, rises 300 metres out of Lake Superior. The Kaministiquia, McIntyre, Neebing and Currents Rivers, along with the McVicar Creek flow through the city to empty into the lake. Fort William First Nation borders the city where Mount McKay, the highest peak in the Nor’Wester Mountain range stands over the city. To the north, the Canadian Shield extends up to Hudson Bay.

Thunder Bay is the largest city in Northwestern Ontario. Its economy was built on pulp and paper, mining, railway, shipping and grain handling. In the 1970s, during the forestry heyday, it was a leading producer of pulp and paper. During that time it was also a shipping hub with more than 1,000 ships going through the Port of Thunder Bay each year. Secondary industries included ship repair, mass transit vehicle manufacturing and specialized equipment assembly.<sup>2</sup> However, since the 1990s, paper mills and grain elevators have been shuttered and mining and manufacturing have decreased dramatically. Many of those jobs were lost.

As the resource-driven economy faded, Thunder Bay emerged as a “knowledge economy” and regional service centre, providing education, training, health, justice and government services, along with employment opportunities that attracted people from across Northwestern Ontario.

In 2016, the population of Thunder Bay was approximately 108,000 people. Taking into account suburban areas, that number grew to about 120,000.<sup>3</sup> These numbers represent a slight drop from the 2011 census. On the other hand, the population of Indigenous people rose. Statistics Canada data from 2016 shows that Thunder Bay had the largest proportion of Indigenous residents among major Canadian cities. Nearly 13 per cent of the population (15,000) identified as Indigenous.<sup>4</sup> In addition to Indigenous people who were born and raised in the city, many Indigenous people from surrounding communities and from the far north move to Thunder Bay.

Among the wide variety of reasons why Indigenous people move to Thunder Bay, are education, family and employment.<sup>5</sup> For many, education, jobs and medical services are often inadequate or unavailable in their home community.

Official census numbers very likely under-represent the number of Indigenous people in Thunder Bay because some reside in Thunder Bay on a temporary basis and so are not captured in census data.

The legacy of colonialism and discriminatory assimilation policies, including residential schools, and institutional racism is apparent in the lives of many Indigenous people in Thunder Bay. Compared to non-Indigenous residents in Thunder Bay, the Indigenous population is younger, less likely to have completed a post-secondary education and have lower incomes and higher unemployment rates. Indigenous youth in the city are also more likely than non-Indigenous children to be living in a single-parent household.<sup>6</sup>

**Racism is part of the social landscape of Thunder Bay. It is recognized to be an issue, and many people in the city have been standing up against it for years.**

There are at least half a dozen committees and programs being run by various community and service groups in Thunder Bay that are dedicated to fighting racism, including a 211 help line to report racism. I commend these initiatives and the people who are involved in them.

Despite these efforts, since 2012, Thunder Bay has been among the top three metropolitan areas in Canada for rates of reported hate crimes. In 2013 and 2015, Statistics Canada reported that Thunder Bay had the highest rate of hate crimes in the country. The majority of these hate crimes were against Indigenous people.<sup>7</sup>

The experiences of Indigenous people in Thunder Bay include being called degrading and racist names in public places. Indigenous people report being followed around in stores by security staff and having change dropped into their hands by retail staff who are unwilling to touch them. Indigenous people regularly request their non-Indigenous partners to return items to stores to avoid differential treatment from store staff.

In one incident, a TBPS officer reportedly told a man, who loaned his sweater to an Indigenous woman, to wash or burn the sweater.

In 2013, the James Street Bridge that links Thunder Bay with the Fort William First

Nation burned. Following the fire, many people began to post anti-Indigenous comments on social media, such as, "That fire on the bridge could just keep travelling toward the rest of the reserve," and, "With the res bridge on fire, we just need to block off the other entrances to the res and this town will be saved."

Indigenous people in Thunder Bay also say that it is common for them to be targeted by people throwing objects from vehicles. They have had eggs, drinks, garbage and bottles thrown at them. These incidents are exacerbated when they are not seen to be taken seriously. For example, the Thunder Bay Chronicle Journal referred to the police "scrambling" in response to incidents of egg throwing. In January 2017, an Indigenous woman was hit with a trailer hitch that was thrown at her from a car window. The woman died six months later. An 18-year-old man stands charged with second degree murder in the case.

The majority of Indigenous people we spoke with in Thunder Bay have a deep distrust of police. That distrust has affected generations of Indigenous people and finds its early roots in the use of police by the government to enforce the Indian Act. The most obvious examples involved the removal or apprehension of children by police to compel their attendance at residential schools, or the participation by police, along with Children's Aid social workers, in the apprehension of children taken into the child welfare system.

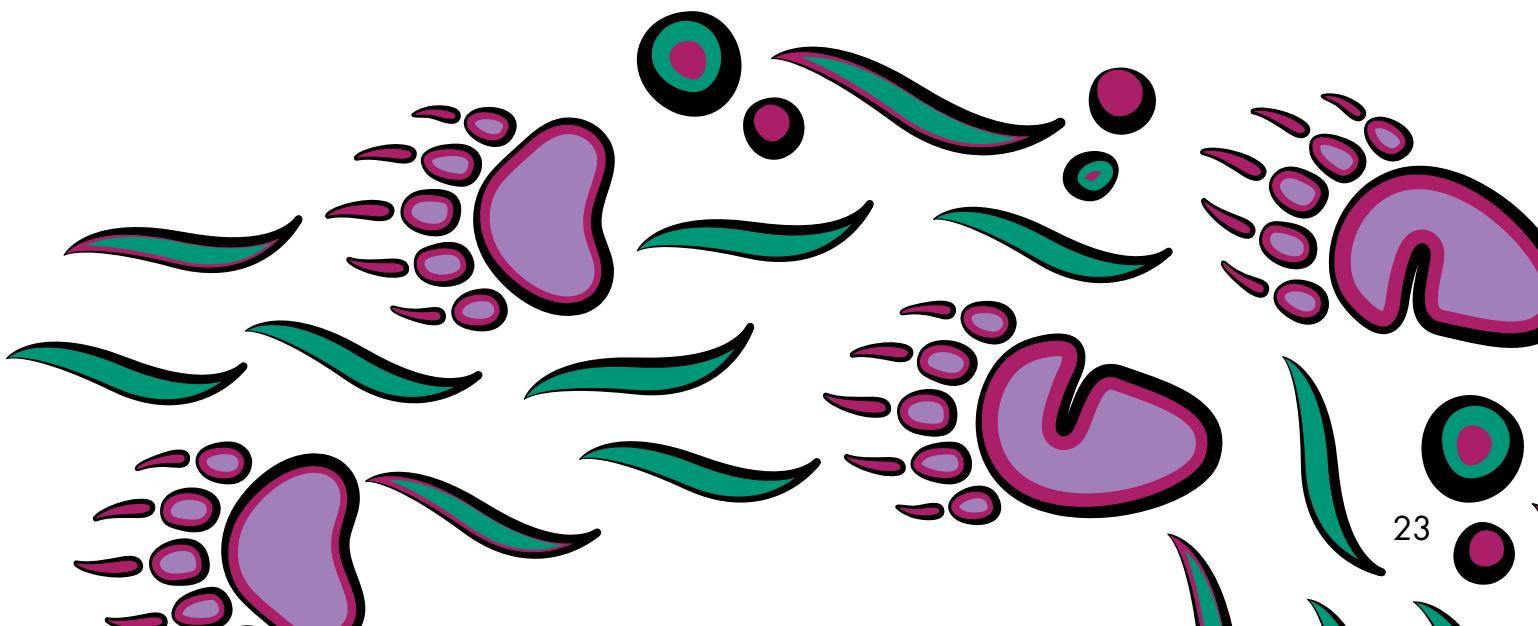
Distrust is reinforced when Indigenous people are both over-policed and under-policed.

Under-policing refers, among other things, to failures to address or adequately address reports that Indigenous people have been victimized. As a group, Indigenous people are more likely than others to be violently victimized. Indigenous people may be seen by police as less worthy victims in comparison to others and so their calls for assistance may be downplayed or even ignored. Crimes against them may not be investigated as thoroughly or prosecuted as vigorously. This, in turn, leads to less trust in police and fewer crimes reported because Indigenous people see little point in doing so.<sup>8</sup>

Over-policing refers, among other things, to the overuse of the law to charge members of a certain community or background for minor contraventions. This may be prompted by negative attitudes or stereotypical thinking about Indigenous people by police. These same attitudes can result in a vicious cycle of both under-policing and over-policing,<sup>9</sup> TBPS and its officers generally do not agree that Indigenous people are either over-policed or under-policed. By contrast, Indigenous people in Thunder Bay repeatedly told me that they have serious doubts about the ability or willingness of the police to truly

serve and protect them. It is apparent to me that there is a crisis of confidence in TBPS within Indigenous communities. In this report, I also find that this is not merely a perception issue, but truly reflective of identified deficiencies in how Indigenous communities are served by TBPS.

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# The Review

Section 57 of the Police Services Act gives me, as Ontario’s Independent Police Review Director, the authority to examine and review issues of a systemic nature that may give rise to public complaints, and make recommendations to police chiefs, police services boards, the Attorney General, the Minister of Community Safety and Correctional Services and any other body. A systemic review is designed to identify and address larger issues of systemic importance, rather than find individual officer misconduct.

As outlined in the terms of reference, this systemic review was designed to examine:

- Existing policies, practices and attitudes of the Thunder Bay Police Service as they relate specifically to Indigenous missing persons and death investigations, and more generally, to issues around racism-free policing, such as “over-policing” and “under-policing”
- Whether missing persons and death investigations involving Indigenous people are conducted in discriminatory ways
- The adequacy and effectiveness of existing policies and identified best practices relating to the above issues
- The adequacy of training and education provided to supervisors and front-line officers relating to the above issues
- The extent to which compliance with existing policies or identified best practices is monitored and supported
- The extent to which officers are held accountable for non-compliance
- The extent to which the service communicates with Indigenous family members, communities and their leaders, engages in community outreach or has specialized liaison units
- The extent to which complaints about the service’s interactions with Indigenous people are inhibited by reprisals or fear of reprisals
- Whether policies, practices, training, education, oversight and accountability mechanisms, and community outreach should be created, modified or enhanced to prevent discriminatory and ineffective policing, particularly in the context of investigations into the disappearances and deaths of Indigenous people

This report is the culmination of my review. It does not purport to exhaustively address all issues identified above.





In carrying out this review, my office examined public complaints made to the OIPRD about TBPS, including the complaints regarding the investigation into the 2015 death of Stacy DeBungee. In addition, we reviewed 37 TBPS cases involving sudden deaths, suicides, homicides and cases within the mandate of the National Inquiry into Missing and Murdered Indigenous Women and Girls.

My office requested case files for sudden deaths, suicides, and homicides going back to 2009. Due to volume, we then selected cases – sometimes randomly and sometimes based on specific criteria. Subsequently, we requested specific case files, including files for the Tammy Keeash and Josiah Begg investigations. We reviewed eight case files pertaining to Missing and Murdered Indigenous Women and Girls. We also requested and reviewed the case files for the seven youth who were the subject of a coroner’s inquest in Thunder Bay.

Of the 37 cases that the OIPRD reviewed, five were the subject of an active, ongoing investigation and some were cases currently before the courts. In those cases, we received limited information so as not to prejudice ongoing matters.

In addition to the case files, we requested and received existing TBPS policies and procedures for missing persons and death investigations, along with details of training provided to officers related to investigations. We reviewed TBPS responses to recommendations made to the service by the coroner’s jury at the Coroner’s Inquest into the Deaths of Seven First Nations Youths,

and recommendations made in other reports, such as the 2002 Thunder Bay Diversity Report and the 2007 Diversity in Policing Phase I Report.

We requested information about TBPS’s officer recruitment process, the Aboriginal Liaison Unit, outreach provided to schools including Dennis Franklin Cromarty High School and to Indigenous people more generally, as well as officer training regarding Indigenous cultural competency. We also requested information about committees, working groups or any forums for dialogue that take place on an ongoing basis between or among TBPS and the Ontario Provincial Police (OPP), Nishnawbe-Aski Police Service (NAPS), Anishinabek Police Service (APS), other participants in the criminal justice system, First Nations and Indigenous organizations or Indigenous people more generally.

My investigators interviewed 16 TBPS officers regarding five of the death investigation cases and the one traffic investigation we examined. These do not include the interviews of 25 officers as part of the conduct investigation pertaining to Stacy DeBungee’s death. We interviewed 16 more current and retired police officers, three civilian members and Acting Police Chief Sylvie Hauth on issues related to my systemic review. We interviewed now retired chief Terry Armstrong and Deputy Chief Roland Morrison from NAPS, and Inspector Derek Johnson and Sergeant Robert Pelletier from APS.

We also met with Ontario’s Chief Coroner, Dr. Dirk Huyer and Chief Forensic Pathologist, Dr. Michael Pollanen, York Regional Police investigators and Crown counsel in Thunder Bay, as well as other participants in the criminal justice system.

We received submissions from TBPS and from other interested stakeholders. All of these submissions helped us to understand the relationship between TBPS and Indigenous communities, as well as potential recommendations for change.

The systemic review team and I collectively visited Thunder Bay more than two dozen times and had over 80 meetings. We met with Indigenous leaders and communities, including Fort William First Nation, Rainy River First Nations and Nishnawbe Aski Nation (NAN), the Métis Nation of Ontario (Thunder Bay), Thunder Bay Métis Council, Indigenous organizations and individuals, as well as Thunder Bay community and service organizations. Among those we met with were:

- Anishnawbe Mushkiki Aboriginal Health Access Centre
- Brain Injury Services of Northern Ontario
- City of Thunder Bay
- Crime Prevention Committee and other City committees
- Dennis Franklin Cromarty High School
- Kinna-aweya Legal Clinic
- Lakehead Social Planning Council
- Lakehead University
- Matawa Learning Centre
- Nishnawbe Aski Legal Services Corporation
- Nokiiwin Tribal Council
- Northern Nishnawbe Education Council
- Ontario Native Women’s Association
- Organizations that serve women, children and youth and people with addiction and mental health issues
- Provincial Advocate for Children and Youth’s Feathers of Hope
- School boards
- Shelter House
- Superior North EMC
- Thunder Bay Drug Strategy Committee
- Thunder Bay Indigenous Friendship Centre
- Thunder Bay Multicultural Association
- Thunder Bay Police Services Board

On September 6, 2017, I convened a meeting with TBPS's Acting Police Chief and Acting Deputy Chief, the Chiefs and representatives from Fort William First Nation and Rainy River First Nations, the Grand Chief of Grand Council Treaty 3 and the Chief Administration Officer and Senior Policy Advisor from Nishnawbe Aski Nation. The purpose of the meeting was to facilitate a process to address issues and improve communication between TBPS and Indigenous leaders.

On September 25, 2017, the OIPRD held a public meeting in Thunder Bay as part of the engagement process for my systemic review. More than 250 people attended to share their perspectives, suggestions and guidance on topics including relations between the police and Indigenous people, racism and bias in policing and recommendations for effective policing. The dialogue was respectful and constructive.

## Content of the Report

I have divided the report into 11 chapters.

**Chapter 2** provides a historical overview of Indigenous people in Canada and in the Thunder Bay area, along with the progression of the relationship between TBPS and Indigenous communities from past to present.

**Chapter 3** sets out what we were told in engagement sessions with Indigenous people and community organizations that serve Indigenous people as well as the general public.

**Chapter 4** provides summaries of submissions made to the OIPRD by organizations as part of this systemic review.

**Chapter 5** outlines recommendations relevant to TBPS that were made in the past.

**Chapter 6** provides a summary of TBPS submissions and related information provided to the OIPRD. It also includes feedback obtained from a number of TBPS officers with whom we met.

**Chapter 7** discusses 11 of the cases my review examined.

**Chapter 8** sets out my findings and recommendations regarding TBPS investigations and operations.

**Chapter 9** sets out my findings and recommendations regarding racism.

**Chapter 10** sets out my recommendations for the implementation of the recommendations.

**Finally, Chapter 11** provides a conclusion to the report.

# A Note about Language

For the purposes of this report, the OIPRD most often uses the term Indigenous to refer to First Nations, Inuit and Métis people collectively.

In interviews, witnesses and officers used a variety of terms to describe a person's identity. Where an individual used a term other than Indigenous, this report generally reproduces that term.

In addition, the OIPRD references historical reports that utilized terms such as "native" or "Aboriginal". For the most part, we have used the exact terms used in the historical reports we cited.

The term "aboriginal peoples" is referred to in Section 35 of the Constitution and recognizes the existing aboriginal and treaty rights of the aboriginal peoples of Canada. The section defines "aboriginal peoples of Canada" to include "Indian, Inuit and Métis peoples of Canada."

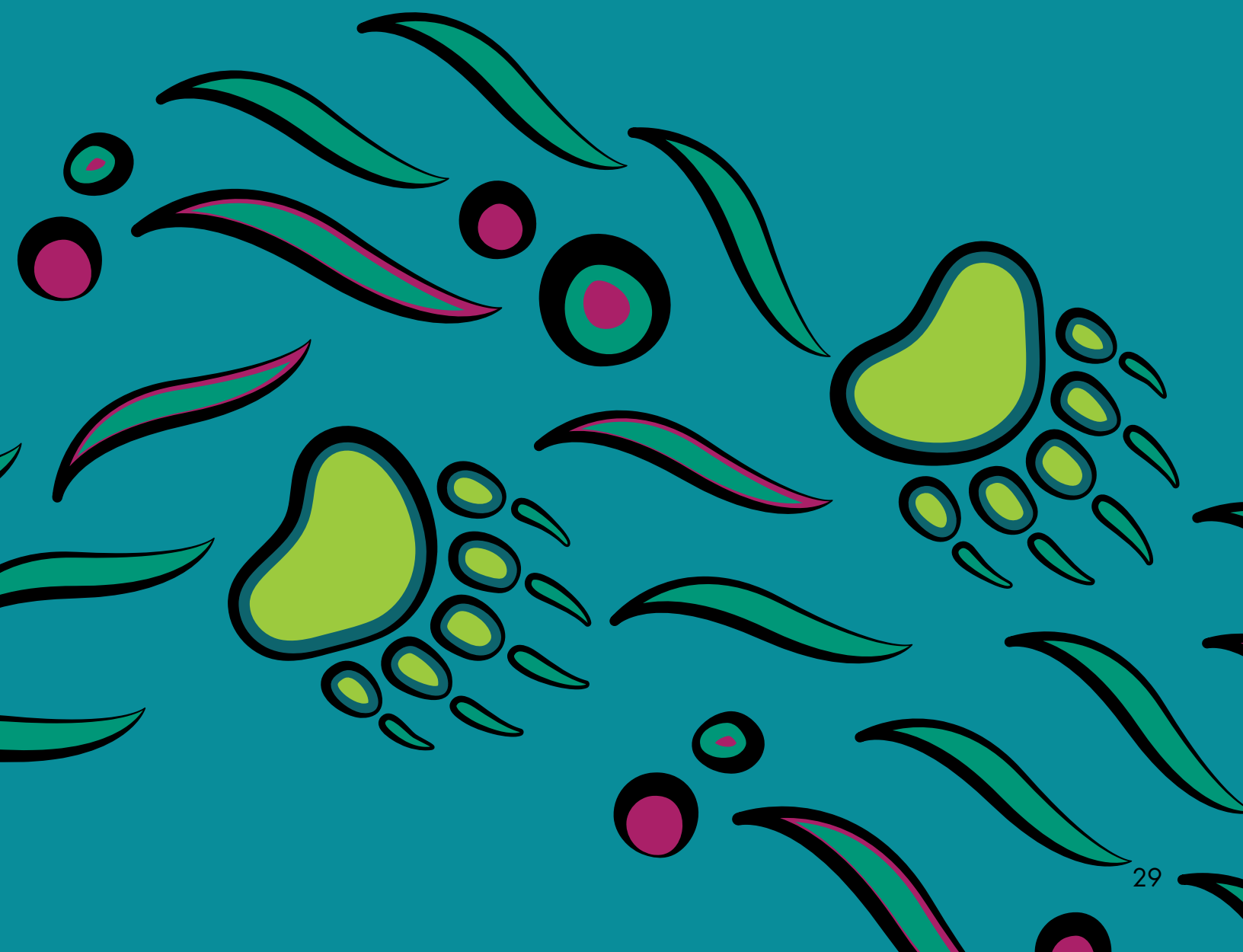
When the OIPRD uses the term "Indian" in Chapter 2, it is in relation to the legal definition under the "Indian Act," described in greater detail in that chapter.

"Indian" is defined as anyone who is registered or entitled to be registered as an Indian under the Indian Act.<sup>10</sup> The federal government refers to Indians who are registered under the act as "Status Indians."

Finally, the OIPRD also utilizes the term "First Nations" throughout the course of the report. First Nations refers to the Original Peoples of what is now Canada. The OIPRD frequently utilizes the term "First Nations" when referring to the Coroner's Inquest into the Deaths of Seven First Nations Youths



# CHAPTER 2: THE HISTORICAL CONTEXT



**To understand the broken relationship between Indigenous people and police, one must first understand the history and impact of colonialization on Indigenous people. Much of the suspicion and distrust that Indigenous people feel toward police is rooted in a history of colonial policies, legal systems and institutions, which included Indian agents and police, used to control, oppress, exploit, assimilate and eradicate them.**

The Royal Commission on Aboriginal Peoples was a Canadian Royal Commission established by an Order in Council in 1991 to investigate the evolution of the relationship among Indigenous Peoples, the Canadian government and society as a whole. It made recommendations to repair those relationships and address obstacles, many of which Indigenous people continue to face today. The Commission submitted its report in 1996.

*The Report of the Royal Commission on Aboriginal Peoples: Looking Forward, Looking Back* states:

“Until recently, North American history has been presented as the story of the arrival of discoverers, explorers, soldiers and settlers from Europe to a new world of forest, lake and wilderness. Indian peoples have been portrayed as scattered bands of nomadic hunters and few in number. Their lands have been depicted as virtually empty – terra nullius, a wilderness to be settled and turned to more productive pursuits by the

superior civilization of the new arrivals. In the same way, Indian people have been depicted as savage and untutored, wretched creatures in need of the civilizing influences of the new arrivals from Europe. This unflattering, self-serving and ultimately racist view coincided with the desire of British and colonial officials to acquire Indian lands for settlement with the minimum of legal or diplomatic formalities. The view prevailed throughout the nineteenth century when the foundations for the Indian Act were being laid. Many Canadians may still maintain such beliefs.”<sup>11</sup>

When Europeans first arrived in Canada, they pursued trade with Indigenous Nations and later made agreements through treaties in order to live permanently in Indigenous territories. These treaties were often oral agreements rooted in sharing resources and sustaining communities, not in land ownership – a concept that does not fit within Indigenous world views. Europeans carefully cultivated and maintained these treaties because they depended on Indigenous people for their own survival.

Over time, Europeans became a majority. As the Crown pursued its goal of securing Indigenous lands to build its new country, treaty negotiations became increasingly complex and rooted in the Western European method that placed an emphasis on the ownership of land and the value of the written word. It is doubtful that Indigenous people knew the written texts they signed differed from the oral agreements they made.<sup>12</sup>

As the Report of the Royal Commission on Aboriginal Peoples: Looking Forward, Looking Back stated, "One of the fundamental flaws in the treaty-making process was that only the Crown's version of treaty negotiations and agreements was recorded in accounts of negotiations and in the written texts. Little or no attention was paid to how First Nations understood the treaties or the fact that they had a completely different understanding of what had transpired."<sup>13</sup>

In the Thunder Bay area, permanent European settlement was established in the early 1800s, with the construction of Fort William by the North-West Company. As the centre of the North-West Company fur-trading empire, Fort William was one of the most important settlements in the interior of North America.<sup>14</sup>

By 1850, the fur trade boom had faded and mining companies were sending prospectors and surveyors into the unceded Indigenous lands bordering on Lake Superior to identify possible deposits. They acquired licences from the colonial government to mine in the region, regardless of whether land had been ceded or surrendered.

Indigenous people in the area had concerns with this practice on the basis that the colonizers had no rights to the lands. The Royal Proclamation of 1763, a document that set out guidelines for European settlement of Indigenous territories in what is now North America, stated that all land would be considered Indigenous land until ceded by treaty. The Proclamation also forbade settlers from claiming land from Indigenous occupants unless it had been first bought by the Crown and then sold to the settlers.<sup>15</sup>

The chiefs in the region, most notably Chief Shinguakouse of Garden River, petitioned the Governor General to request compensation for the lands they had lost to mining.<sup>16</sup> The government was unreceptive to these petitions. In 1849, a group of First Nations and Métis people reclaimed a mining site at Mica Bay on the northeast shore of Lake Superior. The government sent in a force of 100 officers with rifles who reoccupied the mining site and arrested the Indigenous leaders. The leaders were sent to trial in Toronto and then released. These events prompted government officials to begin treaty negotiations.<sup>17</sup>

In 1849 and 1850, colonial commissioners and surveyors entered into negotiations with Chiefs and representatives from Ojibway communities in the Lake Superior region and on September 7, 1850, signed an agreement, known as the Robinson-Superior Treaty. The Treaty granted the Crown access to approximately 43,000 square kilometres of territory on the shoreline of Lake Superior, including the islands, from Batchewana Bay to the Pigeon River, and inland as far as "the height of land," (the division between the Great Lakes and the Arctic watersheds) with the exception of lands the Chiefs chose as reserves. In return the Ojibway people received £2,000, plus an annuity of about £500, and "the full and free privilege to hunt over the territory now ceded by them and to fish in the waters thereof as they have heretofore been in the habit of doing" except in areas that would become private property.<sup>18</sup>



Historically the “Fort William Indians” lived on the western shore of Lake Superior, on the islands and in the interior around Dog Lake. The winter hunting and trapping grounds extended north from Lake Nipigon to what is now Wabakimi Park, west to Lac des Milles Lacs and south to the American border.

The Fort William First Nation Reserve was created in 1853 under the provisions of the Robinson-Superior Treaty. The First Nation contested the boundaries of the reserve in the Treaty when a survey confirmed that the boundaries of the reserve could not be defined as described in the Treaty. The Treaty description assumed that the shore of Lake Superior at Fort William runs in an east-west orientation, when it actually runs in a north-south orientation. The First Nation did not accept the surveyor’s plan for a smaller reserve. The surveyors agreed to recommend that Pie Island be included in the reserve. That recommendation was never implemented. In 1859, Fort William First Nation lands along the Kaministiquia River were surrendered to the Crown and became part of Neebing Township.<sup>19</sup>

Many laws affecting Indigenous Peoples were consolidated in 1876 to become the Indian Act. The act, along with subsequent amendments empowered the federal government, through the Department of Indian Affairs, to unilaterally control every aspect of life on reserves and to create whatever infrastructure it considered necessary to achieve its policy of assimilation.<sup>20</sup>

The act granted the government control over Indigenous political structures, land holding patterns and resource and economic development. It outlawed Indigenous

governance practices and imposed the European electoral governance system. It allowed the government to order that reserve lands be divided into plots and require First Nations people to obtain “location tickets” for individual plots of land. It allowed for the expropriation of portions of reserves for roads, railways and other public works without negotiated settlements. It regulated economic activity by ordering that no one be allowed on a reserve to do business without obtaining a licence from the Indian Agent. It restricted Indigenous people from leaving reserves without permission from the Indian Agent. It introduced the residential school system.<sup>21</sup>

The Indian Act also granted Indian Agents judicial authority, without previous legal training. Not only could Indian Agents lodge a complaint with police, but they could direct that a prosecution be conducted and then sit in judgement of it. The Indian Act prohibited the sale of ammunition and alcohol to Indigenous people. The act required anyone soliciting funds for Indian legal claims to obtain a licence from the Department of Indian Affairs; thereby, granting the government control over the ability of First Nations to dispute land claims.<sup>22</sup>

Furthermore, the Indian Act empowered the department to decide, unilaterally, who was an Indian with the ultimate goal of reducing the number of Indians to zero. The term “Indian” is a legal definition under the Indian Act to mean a person who is “registered as an Indian or is entitled to be registered as an Indian.”<sup>23</sup> The Indian Act made it illegal for Indigenous people to practice certain ceremonies and customs. It removed Indian status from those who earned a university



degree or who became doctors, lawyers or clergymen.<sup>24</sup> It also removed Indian status from men who enlisted in the army. The act introduced unequal treatment for men and women. It deprived Indian women of their status if they married a non-Indian man and it removed Indian status from community members who lived off the reserve for a period of five years.<sup>25</sup> The children of Indians who had lost their Indian status were also no longer legally entitled to have or obtain Indian status. The loss of status also meant Indians lost their right to live on-reserve with their community or to be buried on the reserve with their families.

In 1905, the Canadian government expropriated the entire Fort William First Nation village and land totaling 648 hectares to allow the Grand Trunk Pacific Railway to build a railway terminus grain elevator. The community was evacuated, buildings were torn down, property and farmland were forced to be abandoned and the First Nation burial site was uprooted, with bodies exhumed and moved to a new location. The relocation split the community as the people were redirected to two separate locations. The grain terminus was never completed and the Grand Trunk Pacific Railway went bankrupt. The Canadian government later took over the land and gave it to the Canadian National Railway.<sup>26</sup>

In 1907, Fort William First Nation surrendered 40 hectares of land for a Department of Militia and Defence rifle range and received \$10,000. Again in 1917, Fort William First Nation surrendered 270 acres of land to the City of Fort William for what is now Chippewa Park.<sup>27</sup>

In the early 1900s, the population in the twin cities of Fort William and Port Arthur was predominantly male in keeping with the frontier nature of the economy. It fluctuated in response to changing employment opportunities in railway construction, shipping and silver mining. Early settlement was essentially British and that group controlled the economic and political establishment in both cities until World War II. Immigrants from the Ukraine and Italy populated Fort William. In nearby Port Arthur, immigrants from Finland made up the main immigrant group along with immigrants from Poland, Scandinavia, Slovakia, Greece and Germany. From about 3,000 inhabitants each in the late 1890s, the two cities grew rapidly up to World War I, with Fort William in the lead.<sup>28</sup>

Racism and ethnic prejudice against the recent European immigrants by the dominant British community were very evident during this period. Social survey reports on Fort William and Port Arthur, commissioned by the Department of Temperance and Moral Reform of the Methodist Church and the Board of Social Service and Evangelism of the Presbyterian Church in 1912–1913, referred to the “immigrant problem,” to immigrant overcrowding, intemperate drinking habits, “foreigners,” criminality rates and lack of sanitation.<sup>29</sup> Indigenous people were not included in such surveys and were not considered a part of society.

The boom Thunder Bay experienced in the early 1900s came to an end with the outbreak of World War I. During the war, the economy was maintained through shipbuilding and manufacturing of munitions.

The general policy towards Indigenous service in the war was one of exclusion or limited involvement. However, halfway through the war, the need for reinforcements changed established thinking and the many Indigenous men who had voluntarily enlisted were sent overseas. After the war, Deputy Superintendent General of Indian Affairs, Duncan Campbell Scott drew particular attention to the Indigenous men who served with the 52<sup>nd</sup> Canadian Light Infantry Battalion when he stated:

“Special mention must be made of the Ojibwa bands located in the vicinity of Fort William, which sent more than one hundred men overseas from a total adult male population of two hundred and eighty-two. Upon the introduction of the Military Service Act it was found that there were but two Indians of the first-class left at home on the Nipigon reserve, and but one on the Fort William reserve.... The Indian recruits from this district for the most part enlisted with the 52<sup>nd</sup>, popularly known as the Bull Moose Battalion. Their commanding officer, the late Colonel Hay, who was killed, stated upon frequent occasions that the Indians were among his very best soldiers.”<sup>30</sup>

Indigenous soldiers fought alongside non-Indigenous soldiers as equals during the war. However, upon their return from the war, their treatment did not change. Indigenous veterans were denied the benefits provided to other returning soldiers. They were not treated equally.<sup>31</sup>

The years between the two world wars were characterized by continuing efforts to assimilate Indigenous people and dispossess them of their lands, especially during the depression.<sup>32</sup>

The Canadian government’s policy regarding Indigenous people was to “get rid of the Indian problem.” Prior to the passage of the Indian Act, Indigenous children were expected, then forced to attend industrial schools. An amendment to the Indian Act in 1876 provided for the creation of Indian Residential Schools. A report submitted to the Department of Indian Affairs in 1907, revealed that students in residential schools were living in overcrowded, unsanitary conditions and dying from diseases those conditions spread – primarily tuberculosis.<sup>33</sup>

Despite that report, in 1920, Deputy Superintendent of Indian Affairs, Duncan Campbell Scott spearheaded an amendment to the Indian Act mandating Indigenous children between seven and 15 attend residential schools. Scott told the parliamentary committee, before the amendment became law, “Our object is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question.”<sup>34</sup>

**“Our object is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question.”**

Deputy Superintendent of Indian Affairs  
Duncan Campbell Scott

One of the most racist assimilation policies was the Indian Residential School (IRS) system:

“The removal of children from their homes and the denial of their identity through attacks on their language and spiritual beliefs were cruel. But these practices were compounded by the too frequent lack of basic care – the failure to provide adequate food, clothing, medical services and a healthful environment and the failure to ensure that the children were safe from teachers and staff who abused them physically, sexually and emotionally. In educational terms, too, the schools – day and residential – failed dramatically, with participation rates and grade achievement levels lagging far behind those for non-Aboriginal students.”<sup>35</sup>

The government used the North-West Mounted Police, then the Royal Canadian Mounted Police to apprehend children from their homes to take to residential schools. Police were also used to seek out and return students who ran away from these schools. The Final Report of the Truth and Reconciliation Commission of Canada describes this relationship in stark terms:

“The often-strained relations between Aboriginal people and the police in Canada is directly connected to the history of their experience of policing at residential schools. Not only did the police coercively enforce attendance at residential school, but they also failed to protect the children from serious crimes while they were in the schools.”<sup>36</sup>

Fort William had its own residential school. In 1870, the Immaculate Conception Orphan Asylum was established on Fort William Indian Reserve by nuns to educate young Indigenous girls. In 1895, the orphanage building and the Roman Catholic Church were destroyed by fire. The orphanage was rebuilt as St. Joseph’s Indian Residential School. In 1909, following the expropriation of Fort William Reserve lands by the Grand Trunk Pacific Railway. St. Joseph’s IRS was relocated to the city of Fort William. St. Joseph’s remained in operation for almost a century. It closed in 1970.<sup>37</sup> At its height, in the 1950s, the school housed more than 150 students from reserves in the Thunder Bay area.<sup>38</sup>

In 1959, Dr. M.R. Warren, the director of the local provincial health office, conducted an investigation of the conditions at St. Joseph’s IRS and wrote a “highly critical report for the Ontario director of child welfare.”<sup>39</sup> He found that “the school was overcrowded by nearly 100 per cent.”<sup>40</sup> He determined that there was “no routine medical examination to rule out the possibility of communicable disease” and that “the dishwashing facilities at the school would not be permitted in any other eating establishment in this area.”<sup>41</sup>

The experiences of the students who attended Indian Residential Schools put a human face on Dr. Warren’s documentation. Clara Quisess attended St. Joseph’s IRS in Fort William when she was six years old. She described her fear of the nun who was responsible for her treatment:

“I had to learn the language that she was teaching me to speak. I was not allowed to talk in my language that whenever she asked me she asked me to do something,

whenever she tried to tell me to pronounce this, I have to talk in English, no Native language. And she would yell at me if I was saying, I'm trying to tell her I don't understand and I'm confused and I don't know what to say and how to say it, I was very scared of her. She was always raising her voice at me and she always had this angry look on her face and it felt really intimidating. And I was homesick. I was, like, crying and she yelled at me and told me to stop crying and she called me a crybaby in front of the students and it made me not want to cry anymore. I didn't like her. Deep inside I hated her for being so mean to me and when she told me not to cry and she told me not to speak my language, I felt like I had to keep everything inside me and it made me lonely, that there's nothing out here that could make me happy and feel like it was home."<sup>42</sup>

The St. Anne's IRS operated in Fort Albany for 72 years, between 1904 and 1976, and housed students from Fort Albany, Attawapiskat, Weenusk, Constance Lake, Moose Fort and Fort Severn reserves.<sup>43</sup> Many people from these communities currently reside in Thunder Bay. Mr. Justice Perell of the Ontario Superior Court described the conditions there as follows:

"St. Anne's was the site of some of the most egregious incidents of abuse within the Indian Residential School system. It is known, for example, that an electric chair was used to shock students as young as six years old. It is known that the staff at St. Anne's residential school would force ill students to eat their own vomit."<sup>44</sup>

After the Second World War, some Canadians became more aware of the concept of human rights. Many recognized that Indigenous people were among the most disadvantaged in the country.

This recognition led to revisions to the Indian Act in 1951. Some restrictions were removed. It was no longer illegal for Indigenous people to practice their customs and culture and appear off-reserve in regalia without permission from the Indian agent. Indigenous people could hire legal counsel and women were finally granted the right to vote in band elections. However, new restrictions were instituted for women who married non-status men. Where previously a woman who "married out" could receive treaty annuity payments, the 1951 amendment took away this right.<sup>45</sup>

The amendments to the federal Indian Act gave the provinces jurisdiction over Indigenous child welfare. After almost a century of living under the devastating effects of the Indian Act and a continuing government policy of assimilation, many Indigenous communities suffered severe poverty, socio-economic disparities and high death rates. Rather than providing resources and supports to Indigenous communities, child welfare agencies decided that removing Indigenous children from their homes was a faster and easier solution.

In the 1960s, the removal of Indigenous children from their homes and into state care accelerated, leading to what became known as the "Sixties Scoop." Children were often taken into care without the consent of parents and communities and were adopted out to non-Indigenous families across Canada and

the United States. Children who were not adopted often found themselves living in a succession of foster or group homes, and were often neglected and/or abused.<sup>46</sup>

Indigenous adoptees lost contact with their families, their culture, their language and their identity. These traumas had a deep impact on the children's ability to lead healthy, fulfilling lives. For adoptees who learned about their stolen identity later in life, there was also confusion and emotional distress.<sup>47</sup>

In 1960, sections of the Canada Elections Act were repealed in order to grant status Indians the right to vote in federal elections without losing their Indian status.<sup>48</sup> Status Indians were granted the right to vote in Ontario provincial elections in 1954.

In 1969, Prime Minister Pierre Trudeau proposed the total assimilation of Indigenous people, abolishment of the Indian Act, elimination of treaties and incorporation of First Nation communities into provincial government responsibility as a way to achieve equality for Indigenous people. The proposed policy was unequivocally rejected by Indigenous Peoples across Canada who wanted to maintain their legal distinction and did not believe assimilation was a means to achieve equality. The federal government was forced to abandon the proposal.<sup>49</sup>

## The Relationship between TBPS and Indigenous Communities: Past to Present

In 1970, Port Arthur and Fort William, along with the townships of Neebing and McIntyre were amalgamated to form Thunder Bay. Fort William and Port Arthur police forces were also amalgamated.

The newly created Thunder Bay Police Force had 143 officers and used the former Fort William police station as its main headquarters.<sup>50</sup> The former Prince Arthur station was used as a precinct office. The first phase of its Balmoral Police Headquarters was completed on January 19, 1987.<sup>51</sup> Operational staff from both buildings moved to the Balmoral location. In 1993, phase two of the Balmoral Police Headquarters was completed. For the first time in its history, the Thunder Bay Police Force, since renamed the Thunder Bay Police Service, was stationed in one location.<sup>52</sup>

Today, TBPS's website indicates that it has "just over 300 sworn and civilian members assigned to various functions."<sup>53</sup> Its mission statement states that "Thunder Bay Police Service is committed to working in partnership with the public to serve and protect our communities in a sensitive, efficient and effective manner."<sup>54</sup>



This chapter highlights the progression of the relationship between TBPS and Indigenous communities over the decades to the present day.

When considering the relationship between TBPS and Indigenous communities, it is important to understand the legacy of police involvement in colonial and assimilationist policies and practices identified here meant that Indigenous distrust in the police service preceded its inception. It was necessary for TBPS to work proactively with Indigenous communities to establish a trusting and respectful relationship. However, it is clear that a positive relationship either was not properly formed in the first place, or became increasingly strained over time.

The legacy of residential schools is apparent in the lives of Indigenous people in Thunder Bay. It is estimated that 66 per cent of homeless people in Thunder Bay are Indigenous.<sup>55</sup> Individuals and families who experience poverty, homelessness, substance abuse and mental health issues are at a higher risk of becoming involved in the criminal justice system and of being victimized. Interaction with police is a starting point for involvement in the justice system.<sup>56</sup>

The relationship between TBPS and the Indigenous communities is also revealed through a series of high profile events that demonstrate that the current crisis of confidence in TBPS is not a recent development. These events illustrate the challenges that TBPS faces in its task of restoring the confidence of and repairing the relationship with Indigenous communities.

## Grassroots Committee on Native Unsolved Murders

In the 1990's, Indigenous communities raised concerns about the quality of TBPS investigations into the deaths of Indigenous people, concerns that are very similar to those examined in this review. These efforts culminated in the formation of the Grassroots Committee on Native Unsolved Murders.<sup>57</sup> The Grassroots Committee identified over 30 suspicious deaths of Indigenous people, where it was alleged that TBPS did not conduct a sufficiently thorough investigation.<sup>58</sup> Questions were also raised about the adequacy of reward amounts offered to the public for information leading to the arrest and conviction of the perpetrators of crimes against Indigenous people.<sup>59</sup>

In November 1993, the Grassroots Committee circulated a petition calling on the federal government to hold a public inquiry "to investigate why the murders of native people were treated differently by the Thunder Bay Police Department."<sup>60</sup> The petition attracted 3,000 signatures. The call for a public inquiry was supported by the Ontario Native Women's Association.<sup>61</sup> In addition, then Chief Cheri Pervais of Fort William First Nation (FWFN) tabled a resolution entitled "Racism in Thunder Bay" which supported the Grassroots Committee.<sup>62</sup> The Chiefs of Ontario adopted the resolution. At the time, Chief Pervais indicated that Ontario Chiefs wanted to see the resolution taken "to a higher level." She also remarked that "if all of these murders were French or Finnish people, somebody would be addressing this issue."<sup>63</sup>



The murder of Sandra Johnson on February 13, 1992, became a flashpoint for members of Indigenous communities. Sandra Johnson was last seen leaving her residence at 1:30 a.m., and was discovered hours later, naked on the frozen surface of the Neebing-McIntyre floodway.<sup>64</sup> Her murder remains unsolved.

On December 15, 1993, the lone Indigenous member of the Thunder Bay Police Services Board, Phillip Edwards, burned a copy of the Ontario Human Rights Code at a demonstration in front of police headquarters to protest what he alleged was systemic discrimination in the investigations of the deaths of Indigenous women. Mr. Edward's two-year provincial appointment to the TBPSB ended on January 31, 1994. He was not renewed.<sup>65</sup>

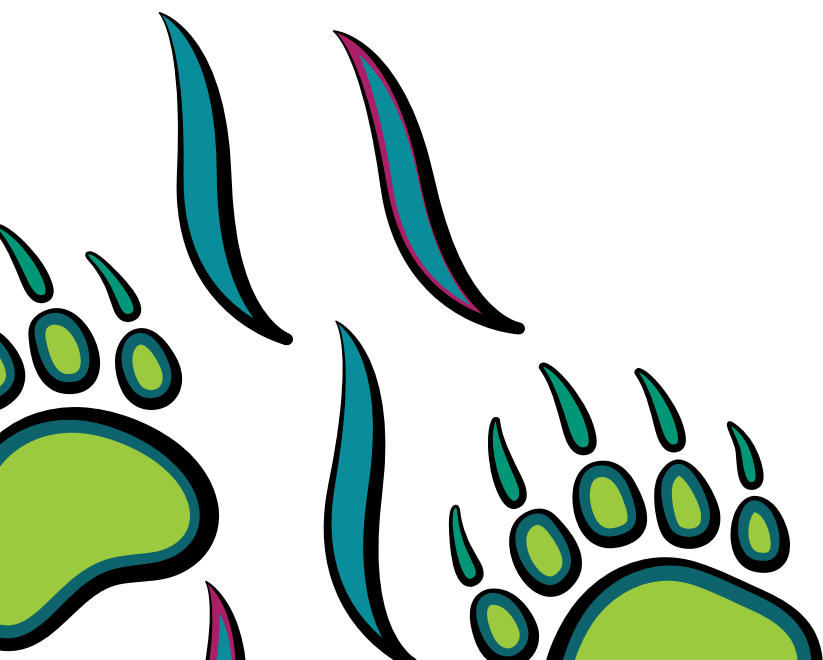
TBPS flatly denied the allegations that its investigations were affected by racism. The TBPS spokesman stated: "We don't differentiate on a homicide because of race. That has nothing to do with it."<sup>66</sup> TBPSB supported these denials. TBPSB Chair stated that he has "yet to find anything concrete" in the allegations and "I've certainly looked at it and I cannot find any negligence on our force's behalf."<sup>67</sup>

## Coroner's Inquest into the Deaths of Seven First Nations Youths

Between 2000 and 2011, seven First Nations youths, Jethro Anderson, Curran Strang, Paul Panacheese, Robyn Harper, Reggie Bushie, Kyle Morriseau and Jordan Wabasse, died while they were in Thunder Bay attending school. All of the students were from northern First Nation communities and had moved to Thunder Bay to attend secondary school. The death of each of the students was investigated by TBPS. Five of the students were found in the McIntyre or Kaministiquia Rivers.<sup>68</sup>

Indigenous communities raised serious questions about how the youths ended up in the rivers and the quality of TBPS missing persons and death investigations.

A Coroner's Inquest into the Deaths of Seven First Nations Youths was held in Thunder Bay between October 5, 2015, and June 28, 2016. Throughout the inquest, the conduct of TBPS officers was subjected to some scrutiny. Some parties to the inquest alleged that TBPS investigations were affected by racial discrimination. The inquest jury classified the deaths of three of the students as "undetermined." The jury directed recommendations to TBPS with respect to policies, training and media communications in missing persons investigations. The jury also recommended the implementation of a process to improve TBPS's cultural competency training.<sup>69</sup>



## Profiling an Indigenous Youth

In November 2007, during a Dennis Franklin Cromarty High School class trip to the Thunder Bay police station, a youth from Fort Severn First Nation was “pulled aside by a police officer who remarked that his T-shirt, which prominently displayed the image of a Native war chief, is associated with gangs.”<sup>70</sup> The officer, who was in plainclothes, questioned the youth. A uniformed officer was also present during the questioning.

The then Grand Chief of Nishnawbe Aski Nation said that the 17-year-old youth was asked to remove his shirt in front of his peers and was taken to a separate room where he was questioned and photographed without an adult present.<sup>71</sup>

At the time, the Chief of Fort Severn First Nation explained that Warchief Native Apparel, “is a clothing line meant to promote pride and unity in First Nations rather than endorse gang violence.”<sup>72</sup>

The then Grand Chief of NAN said that the “confrontation was unfortunate because the school trip was supposed to be a way for the students to be introduced to an important institution... so that if they fall into trouble with something, somewhere, they can depend on the police for protection like everybody else.”<sup>73</sup> He also pointed out that the incident speaks to the larger issue of racial profiling of Indigenous people by police: “What crime did he commit other than being a native person? Wearing a shirt the policeman didn’t like?”<sup>74</sup>

Following the incident, a TBPS inspector indicated that the youth was not charged and stated that the matter was under internal investigation after a formal complaint was made under the Police Services Act.<sup>75</sup>

In a letter to the youth about the plainclothes officer’s involvement in the incident, J.P. Levesque, then a superintendent, wrote:

“The officer shall receive a written reprimand that will stay on his employment record for a period of two years... Further, the officer will participate in training involving powers of arrest, detention, and search and seizure. Lastly, the officer will apologize to you in writing and in person at your convenience.”<sup>76</sup>

The letter also stated that the photographs taken of the youth would be destroyed, as they were taken without consent. With respect to the uniformed officer’s involvement in the interaction, police adjudicators deemed to be “relatively minor.” J.P. Levesque wrote, “Although I am unable to conclude that there may have been misconduct, I recognize the principal concern that you have outlined in your complaint and his involvement in this incident.”<sup>77</sup>

Counsel for the youth sent a letter to the Ontario Civilian Commission on Police Services in February 2008, expressing concerns about the findings: “A police officer stood by and watched a fellow officer wrongfully detain and then illegally search a youth. Such condemnation on the part of a police officer constitutes a neglect of duty and discreditable conduct.” The letter indicated that TBPS failed to investigate breaches to the youth’s Charter rights



and also did not consider how the youth's Indigenous identity played a role in the actions of the officers."<sup>78</sup>

The youth filed an application to the Human Rights Tribunal of Ontario under the Ontario Human Rights Code against the Thunder Bay Police Services Board. The application was resolved through a settlement agreement, the terms of which are confidential.

## **TBPS News Release that Reflected Racial Stereotyping**

In September 2012, TBPS issued a news release under the title "The SCPOE" [sic] (referring to Scope mouthwash) stating that "the fresh breath killer was captured in Kenora." The release was issued in error by a TBPS officer, who had intended to send it to fellow officers as a "joke." A second release was issued minutes later asking the media to ignore the original news release. The "joke" news release was referring to the arrest of a suspect in the murder of an Indigenous man. Empty bottles of mouthwash were located at the scene of the victim's death.<sup>79</sup>

Responding to concerns from Indigenous communities regarding the erroneous news release, TBPS officials refused to acknowledge any racial overtones of the language used. The then deputy chief stated "We're doing an internal investigation right now but I suspect he was doing it out of a little bit of misdirected levity... This is not a racial issue. We don't see it as a racial issue. At this time we believe it's not a racial issue unless something in our investigation turns up something different."<sup>80</sup>

Following these public statements, the family of the Indigenous man and three First Nations filed a human rights complaint against TBPS alleging racial discrimination in respect to the "joke" news release.<sup>81</sup>

The application alleged that the references to "Scope" and "fresh breath" alluded to racial stereotypes associating Indigenous people to alcohol abuse and that the release was demeaning to the victim.<sup>82</sup> At a news conference announcing the human rights complaint, the daughter of the victim, stated: "My family is really, really hurt by this comment... I hope out of this application that things can be done in the right way."<sup>83</sup>

The TBPS Executive Officer told the media that the service was "disappointed" and "discouraged" by the issuance of the human rights complaint by the family and three affected First Nation communities. He said, "When something like this happens, of course it feels like a set-back. It does feel insulting too, to a lot of the hard work that is done by our members on behalf of every member of this community."<sup>84</sup>

TBPS conducted a discipline investigation and the matter was addressed through informal discipline.

Note that where a police chief initiates an internal conduct investigation resulting in a finding of misconduct or unsatisfactory work performance, the police chief may resolve the matter by imposing a penalty on a police officer if the misconduct is not regarded as a serious matter. This is called "informal discipline."

## Racially-Motivated Sexual Assault Investigated

In 2012, TBPS investigated an allegation of a sexual assault on an Indigenous woman that the service deemed to be racially-motivated. The woman was reportedly grabbed off the street by two men described as Caucasian, dragged into a car, taken outside the city, sexually assaulted, strangled and left for dead. The victim was told that she was being assaulted because she was an Indigenous woman and that they had done it before and would do it again. Media reported that the assailants called her a “squaw and dirty Indian.”<sup>85</sup> The men also made reference to recent Idle No More protests.<sup>86</sup> Media reported that TBPS conducted a “very thorough investigation.” No arrests were made.<sup>87</sup>

At the time of the incident, it was reported that people in Thunder Bay questioned whether the police service had the credibility to investigate what appeared to be a racially-motivated criminal allegation.

## “Starlight Tour” Allegation Found to be False

In 2012, a student attending Dennis Franklin Cromarty High School alleged that Thunder Bay Police officers picked him up and dropped him off on the outskirts of the city on a December night, leaving him to walk home. The allegation received a lot of media coverage. The OPP investigated the matter. OPP investigators interviewed officers and potential witnesses, examined police vehicle GPS records and commercial surveillance videos and other related evidence.

In the end, the teenager admitted he fabricated the story. A TBPS news release stated that the male provided TBPS with a written apology. He also apologized to the families and children of the officers for having made the accusation.

In an interview, one Thunder Bay officer spoke about what happened when the teenager was confronted and how it affected police officers:

“[The teenager said,] ‘I made it all up because I was mad. I went out. I didn’t have a good excuse to my parents where I was, so told them that police grabbed me and dragged me out in the middle of nowhere.’ So in the end, here’s what bothered the officers. Everybody accused us. The media accused us that we were these evil people that did Starlight Tours. So, in the end, the kid lied about us. We suffered public ridicule.”

The principal of Dennis Franklin Cromarty High School told the media he was grateful that the allegation was false, and that as a community member of Thunder Bay, “we need to trust our police service.”<sup>88</sup>

## Police Investigate Racist Facebook Sites

In 2015, TBPS launched an investigation of Facebook pages that the service characterized as “extreme racism” against Indigenous people. The pages posted photos, videos and comments mainly about Indigenous people. In a statement, TBPS called the remarks derogatory and extremely offensive. Following the investigation, the police said they could not establish criminality.<sup>89</sup>

## Stacy DeBungee's Death and Investigation

In October 2015, the body of an unidentified Indigenous male was found in the McIntyre River. Three hours after the discovery of the body, TBPS issued a news 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." Subsequently, TBPS issued another news 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." The DeBungee investigation is examined in detail later in this report. The predetermination by TBPS that the death was not suspicious before the autopsy examination had been conducted contributed to existing beliefs that Indigenous deaths were not investigated in an adequate, bias-free way.

## Police Called to Woman in Distress

In March 2016, two citizens responded to an Indigenous woman's calls for help on a Thunder Bay street late one night. The woman was in distress, naked and bruised. The two citizens called 911 and one of the men gave the Indigenous woman his sweater while they waited for the ambulance. When the police arrived, the man overheard the woman telling TBPS officers that she had been paid for sex and that the man had tried to kill her and threatened to throw her in the lake. The man who gave the Indigenous woman his sweater told the media that the TBPS officer handed his sweater to him by two fingers and said that

"she was contagious" and to "wash or burn my sweater as soon as I got a chance." Two months later a Thunder Bay police spokesperson told media, "After a thorough review of this incident, which included a consultation with the Crown, the evidence did not support criminal charges."<sup>90</sup>

## TBPS Takes Walk-A-Mile Training

The Walk-A-Mile Film project is a series of five short documentary films designed to educate and facilitate discussions about the "reality of the life and history of Aboriginal peoples." The project was a collaboration between the City of Thunder Bay's Aboriginal Liaison Unit and Thunderstone Pictures. The project stemmed from the City of Thunder Bay's "declared commitment to strengthening relationships between the City of Thunder Bay and urban Aboriginal peoples." The films, created by an award winning filmmaker, focus on subjects such as violence against Indigenous women, racism, and Treaties.<sup>91</sup>

The City of Thunder Bay trained volunteer facilitators to use the Walk-A-Mile films to "address misinformation and myths that persist in the broader community about Aboriginal peoples," in order for the community to have "well-informed discussions about moving forward together as a community on the road to respectful relationship and community building."<sup>92</sup> Part of this initiative involved delivering the Walk-A-Mile training to TBPS officers.

In July 2016, media reported that a facilitator was verbally assaulted by TBPS officers during a training session. The trainer described the behavior of officers as "disruptive and dismissive" and reported that

she was accused of lying about statistics on missing and murdered Indigenous women. The trainer also alleged that she was asked for “proof of differential police treatment of Indigenous and non-Indigenous people.”<sup>93</sup>

Through its official spokesperson, TBPS stated that it was a “misunderstanding.” The TBPS Executive Officer provided the explanation that “you can misread people’s tone, attitude and body language in these kinds of sessions.”<sup>94</sup> The controversy surrounding these events would create further tensions in the months to follow.

## A Racist Facebook Post

Following the incident in which a Walk-A-Mile facilitator alleged she was “verbally assaulted” by TBPS officers, the Thunder Bay Chronicle Journal published an editorial titled “Racism claim not backed up.” The editorial quoted then Chief Levesque as describing the CBC story on the Walk-A-Mile training session with TBPS officers as “biased and inaccurate.” The editorial concluded that “police and the city are trying hard to improve relations with Thunder Bay’s aboriginal community. Surely that is the more important story.”<sup>95</sup>

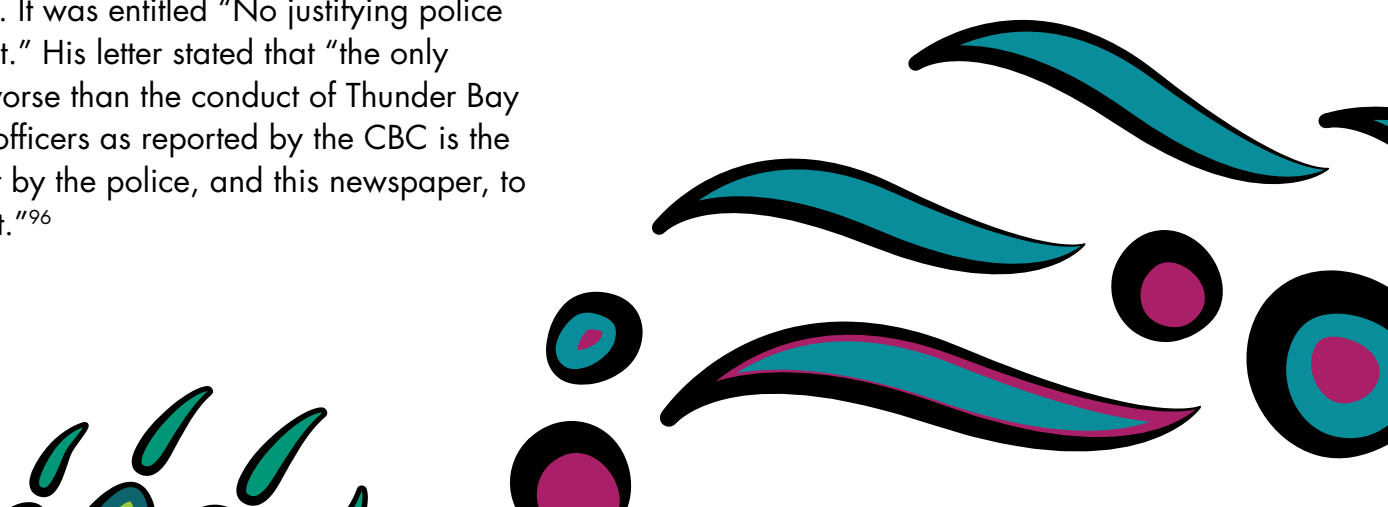
Two days after the editorial was published, the Grand Chief of Nishnawbe Aski Nation wrote a letter to the editor of the Chronicle Journal. It was entitled “No justifying police conduct.” His letter stated that “the only thing worse than the conduct of Thunder Bay Police officers as reported by the CBC is the attempt by the police, and this newspaper, to justify it.”<sup>96</sup>

On September 17 and 18, 2016, a TBPS constable made three posts through his personal Facebook account while off duty. The constable, using his actual name, first posted on the newspaper’s Facebook page: “Give your head a shake Alvin Fiddler I think it’s too foggy to see the truth.”<sup>97</sup>

Another Facebook user commented on the constable’s post, writing “if you can’t see the racism in the TBPS I suggest you open your eyes to reality... it’s pretty scary and I’m glad he’s speaking up about it when others won’t.” The constable countered with, “You are blind to the real world.” The Facebook user then asked, “The real world as in what?”<sup>98</sup>

In response to this question, the constable posted the following statement on the newspaper’s Facebook page:

“Natives are killing natives and it’s the white mans [sic] fault natives are drunk on the street and its [sic] white mans [sic] fault natives are homeless and its [sp.] white mans [sic] fault and now natives are lying about how they are being treated by white men an explanation is given and it’s the white men who are lying. Well let’s stop giving the natives money and see how that goes.”<sup>99</sup>



The constable's public comments were first brought to the attention of TBPS by an Aboriginal Peoples Television Network journalist. The constable was suspended with pay under the Police Services Act.<sup>100</sup> Four other officers were put on administrative duties in relation to their positive response to the constable's Facebook posts. The four officers were not named publicly, but Facebook posts in the name of a second TBPS officer were made during the constable's Facebook exchange.<sup>101</sup>

After initially investigating the incident, TBPS referred the matter to the OIPRD for further investigation. The constable admitted that he was the author of the Facebook posts to both TBPS and the OIPRD.<sup>102</sup>

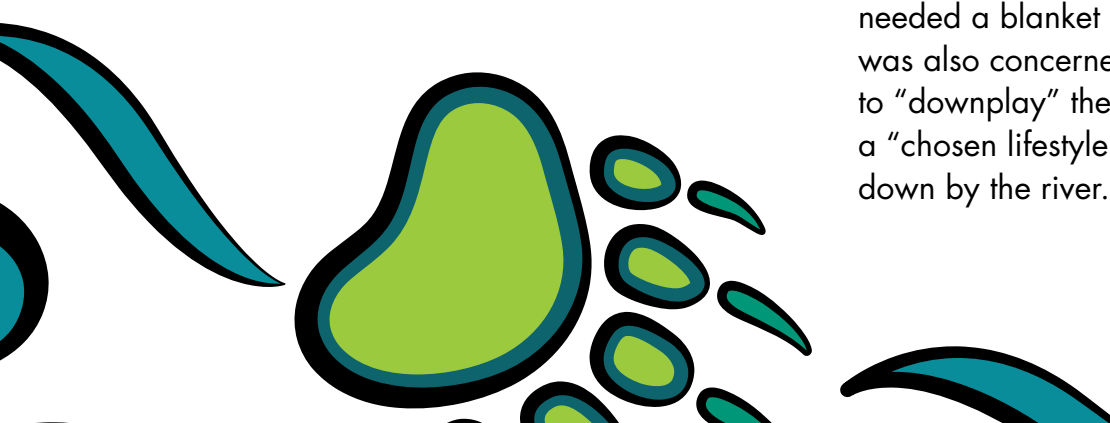
On March 8, 2018, the constable pled guilty to one count of Discreditable Conduct. At the hearing, he apologized to TBPS, the community and to Grand Chief Fiddler. As a penalty, the constable was required to forfeit 40 hours, which meant that he was required to work on his annual leave days or rest days until the hours were met. The disciplinary hearing adjudicator acknowledged the harmful effects that the constable's comments caused:

"The Thunder Bay Police Service will not tolerate unacceptable behavior from its members and views this misconduct as serious. Posting such comments on Facebook or any other media or electronic process is totally unacceptable. The ramification of this act has led to more distrust of the service. I hope [the constable] recognizes the potential harm that was created by his actions. A penalty must be imposed to protect the interest of the public we serve and send a message to the organization and its members."<sup>103</sup>

## Indigenous Man Thrown in the River (2016)

In October 2016, a Thunder Bay restaurant owner was closing her business for the night when she was approached by an Indigenous man who was soaking wet and bleeding from the head. The man told her that two white men got out of a blue truck, beat him up and threw him in the river. He got out of the river but the men threw him back in. The man was in distress and the restaurant owner told him that they should call police. The man didn't want to. He said that he just wanted to go to his mother's house. He was upset and kept repeating, "Why would someone do this?"

A police cruiser passed by and the restaurant owner flagged it down. The first responding officer called for another officer to attend and they took a statement. The restaurant owner was concerned because the man needed a blanket and medical care. She was also concerned that the police seemed to "downplay" the incident, saying it was a "chosen lifestyle" for this individual to go down by the river.



In May 2017, following the deaths of Tammy Keeash and Josiah Begg, the restaurant owner was disturbed by potential similarities to the incident she had reported. The restaurant owner contacted a lawyer who in turn contacted police. A TBPS investigator came to the restaurant owner's residence to ask her to provide another statement. The restaurant owner told the TBPS officer about her concerns regarding the derogatory remarks made by the first responding officer. She felt the investigator was trying to "poke holes" in her original statement because it was different from the lawyer's email, which mistakenly said she had called police instead of saying she had flagged the officer down.

The lawyer informed a media outlet about the incident and the restaurant owner agreed to speak with a reporter. A few days later, the TBPS investigator involved with the case came to the restaurant to tell the owner her name would be in the media. She questioned the TBPS investigator as to why he came to tell her that and he indicated that it was normal to notify people in that kind of situation.

When relaying this incident to members of the OIPRD's systemic review team, the restaurant owner said the TBPS investigator created mistrust because she did not think it was appropriate for him to stop at her restaurant to tell her she would be in the media. The case remains unsolved and open.<sup>104</sup>

## Chronology of Events Following the Systemic Review Announcement

### November 2016

- TBPS leaders visit Saskatchewan police services in Regina, Saskatoon and Prince Albert to seek advice and ideas on how to provide police services to Indigenous communities. They looked at various policies and procedures and recruitment and training strategies implemented by these services.<sup>105</sup>
- Over the previous two years, gang members from Ottawa and Toronto began to establish a presence in Thunder Bay, drawn by a lucrative market for illegal drugs. In November 2016, a 23-year-old Ottawa man went missing in Thunder Bay. Police believed the man was member of an Ottawa gang and was linked to criminal activity. Media reported that police suspected foul play in his disappearance.<sup>106</sup>

### December 2016

- The Thunder Bay Police Services Board votes unanimously to add an Indigenous representative to the board.<sup>107</sup>



## January 2017

- Around midnight on January 28, 2017, Barbara Kentner was walking on a Thunder Bay street with her sister when she was hit in the stomach by a trailer hitch thrown from a passing car. Both Ms. Kentner and her sister described the suspect, who was hanging out of the window, as a Caucasian male, in his early 20's, with blonde hair. The male shouted something to the effect of, "Yeah, I got one of them," and laughed. Ms. Kentner required surgery for internal injuries received in the attack. Police charged 18-year-old Brayden Bushby with aggravated assault in connection with the incident.<sup>108</sup>

## February 2017

- On February 13, an Indigenous woman was struck by a motor vehicle in Thunder Bay and suffered a broken leg and a concussion. Two days later, while recovering from surgery in the hospital, she received a provincial offences ticket from a TBPS officer for "entering the highway unsafely." The driver faced no charges.
- When the woman's family raised concerns about the manner in which the ticket was issued especially in light of the questions raised about the investigations conducted by TBPS involving Indigenous people, a TBPS spokesperson responded that police "welcome the opportunity to address concerns of the family when we receive a complaint."<sup>109</sup>

## March 2017

- An Indigenous Resource Person joined the TBPSB. The Indigenous Resource Person is a non-voting, volunteer position.
- On March 21, the body of a woman was discovered near the Canadian Tire store on Fort William Road in Thunder Bay. The forensic pathologist determined the cause of death to be "hypothermia and ethanol intoxication in a woman with a left ankle fracture." This determination appeared to resolve the matter without further meaningful investigation by TBPS.<sup>110</sup>

## April 2017

- Indigenous youth and others began using the social media hashtag #ThisIsThunderBay to post stories about interactions they experienced with people in Thunder Bay, including items being thrown at them on the streets and interactions with the police.
- The City of Thunder Bay launched #IChooseTBay on social media to encourage residents to post stories and photos about why they choose to live in Thunder Bay.

## May 2017

- On May 7, the body of 17-year-old Tammy Keeash from Weagamow First Nation, also known as North Caribou Lake First Nation, was found in the Neebing-McIntyre Floodway running through Chapples Park. TBPS launched an investigation. On May 12, 2017, TBPS issued a news release stating that Tammy's death was consistent with drowning and there was no evidence to indicate criminality in her death.<sup>111</sup>
- On May 8, Josiah Begg, from Kitchenuhmaykoosib Inninuwug (KI) First Nation was reported missing in Thunder Bay. The search for Josiah lasted 12 days. On May 18, members of the OPP Underwater Search and Recovery Team pulled a body from the McIntyre River. On May 23, the Chief Coroner's Office confirmed the deceased was Josiah Begg. In an investigation update, TBPS requested that anyone with information relating to Josiah's disappearance and death come forward. The update also indicated that TBPS was continuing to assist the Coroner's Office with the investigation.<sup>112</sup>
- Nishnawbe Aski Nation Grand Chief Alvin Fiddler, Treaty #3 Grand Chief Ogichidaa Francis Kavanaugh and Rainy River First Nations Chief Jim Leonard held a news conference at Queen's Park in Toronto, where they called on the RCMP to investigate the deaths of Tammy Keeash, Josiah Begg and Stacy DeBungee, citing a crisis of confidence in TBPS. They also called on the Ontario Civilian Police Commission (OCPC) to investigate the "administrative failures" of the Thunder Bay Police Services Board.<sup>113</sup>

- The Bear Clan patrol of Thunder Bay waterways began. The Bear Clan Patrol is a group of Indigenous volunteers who patrol Thunder Bay waterways and streets to help protect people who experience homelessness or other vulnerabilities.<sup>114</sup>

## June 2017

- TBPSB announced that Deputy Chief Sylvie Hauth was appointed Acting Police Chief, and Inspector Don Lewis was named Acting Deputy Chief.
- The Weagamow First Nation Chief and Councillors led a prayer walk in Thunder Bay in memory of lost community member, Tammy Keeash, and Josiah Begg from Kitchenuhmaykoosib Inninuwug First Nation. More than 300 people joined the walk, including family and community members from Weagamow First Nation, Fort William First Nation Chief Peter Collins and council representatives, Nishnawbe Aski Nation Grand Chief Alvin Fiddler, Mayor Keith Hobbs, representatives of City Council, Acting Police Chief Sylvie Hauth and members of the TBPSB.<sup>115</sup>
- The Ontario Civilian Police Commission launched an investigation into the operation of the Thunder Bay Police Services Board in response to the written request from Grand Chief Alvin Fiddler (Nishnawbe Aski Nation), Grand Chief Ogichidaa Francis Kavanaugh (Grand Council Treaty #3), and Chief Jim Leonard (Rainy River First Nations).



- In a news release, the OPP Commissioner confirmed that the OPP had “recently completed a review of the investigation relating to the death of Stacy DeBungee referred to OPP by the Chief of TBPS,” and that the report was provided to TBPS. The Commissioner also clarified the OPP’s role in the Thunder Bay case, stating that where the OPP “undertakes an investigation at the request of another police leader ... the final report is provided to the requesting agency. It would be up to that agency or its leadership to determine whether to make public the results of the report. If during the course of that investigation, criminal charges were warranted, the OPP would lay criminal charges.”<sup>116</sup>
- Acting Police Chief Sylvie Hauth, along with Acting Deputy Chief Don Lewis and TBPSB Chair Jackie Dojack, held a news conference to provide “updates on a number of matters of interest to the public.” These matters included the OCPC’s investigation of TBPSB, the OPP’s review of the Stacy DeBungee investigation, an update on the Tammy Keeash and Josiah Begg deaths, and the call for the RCMP to investigate these deaths. They also described initiatives being undertaken by the police service. Acting Police Chief Hauth told reporters that the Thunder Bay police didn’t believe that bringing in the RCMP was a “practical or necessary action to take.” In response to questions, she told reporters, “We have a job to do and a community to serve and protect and we will continue to do so...I’m not negating the fact that there are challenging times. We have a lot of things on our plate right now, but it is business as usual; we have a job to do.”<sup>117</sup>
- Media reported that two Caucasian men attempted to force an Indigenous teenaged boy into a vehicle. The teen threw a rock at one man and bit the other in an effort to break free. He freed himself and passersby called TBPS and an ambulance, which took him to hospital. According to a media article, TBPS were investigating and had asked witnesses to come forward.<sup>118</sup>
- Statistics Canada reported that Thunder Bay had the highest rate of reported hate crimes in the country in 2015. Its report stated that almost one-third of reported hate crimes in Canada victimized Indigenous people in Thunder Bay.<sup>119</sup>
- Ontario’s Chief Coroner requested York Regional Police to assist the coroner’s investigation into the deaths of Tammy Keeash and Josiah Begg.
- An Indigenous man, found bruised and unconscious behind a Thunder Bay hotel, died in hospital after being taken off life support. TBPS began a criminal investigation. The case remains unresolved.<sup>120</sup>
- The Lakehead Social Planning Council, Diversity Thunder Bay and the City of Thunder Bay’s Anti-Racism and Respect Advisory Committee’s Incident Reporting Working Group introduced a one-year pilot project to provide telephone, online, and in-person racism incident reporting through the City’s 211 service.<sup>121</sup>

## July 2017

- Barbara Kentner, the Indigenous woman who, in January 2017, was hit by a trailer hitch thrown by a passenger from a passing vehicle died.
- An Indigenous man was found unresponsive near the McVicar Creek and transported to hospital where he died. TBPS officers charged a man with second degree murder.<sup>122</sup>
- An Indigenous man died in a cell at the TBPS station. The Special Investigations Unit ultimately determined there were no reasonable grounds to lay criminal charges against a TBPS officer.<sup>123</sup>
- The Ontario Civilian Police Commission announced the appointment of retired judge and current Senator, the Honourable Murray Sinclair as the independent investigator into the Thunder Bay Police Services Board. In its announcement of the investigation, the OCPC cited “serious concerns about the state of civilian police oversight and public confidence in the delivery of police services in Thunder Bay.” Senator Sinclair was the first Indigenous judge in Manitoba and chaired the Truth and Reconciliation Commission before being appointed as a senator in 2016.<sup>124</sup>
- Statistics Canada reported that Thunder Bay had Canada’s highest homicide rate per 100,000 population in 2016.<sup>125</sup>

## August 2017

- Fort William First Nation, Nishnawbe Aski Nation and the City of Thunder Bay signed a Statement of Commitment to First Nation Youth and Families pledging to fight racism in the city and to work collaboratively to make it a safe, welcoming place for First Nations students and families. The statement also acknowledged individual and systemic racism in the city.<sup>126</sup>
- The body of an Indigenous male was found beside McVicar Creek near the Marina Park Overpass. Calling it a suspicious death, TBPS began an investigation. The death was later ruled a homicide. An individual was charged with murder.<sup>127</sup>

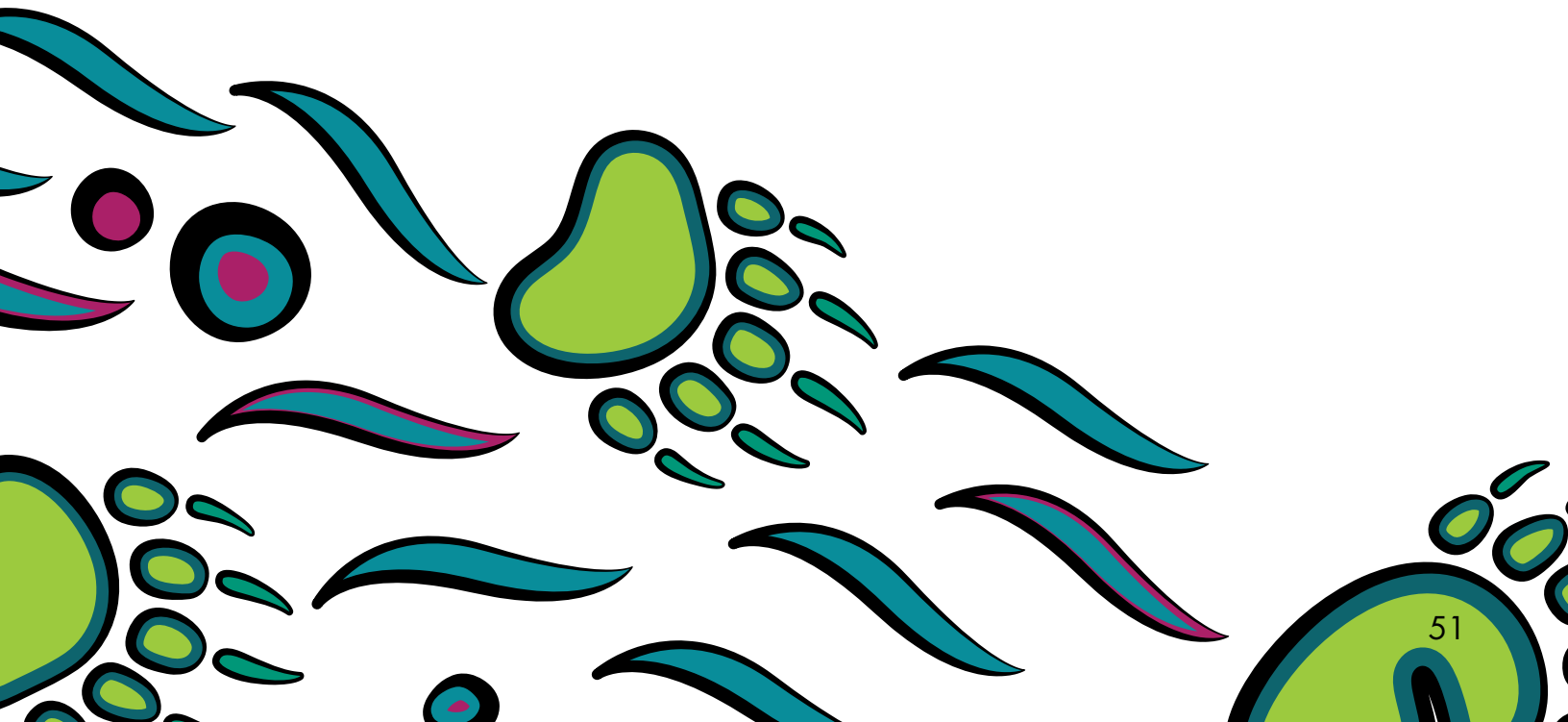


## September 2017

- The body of an Indigenous man was pulled from the Neebing-McIntyre floodway. Thunder Bay police and the coroner launched an investigation into the death they deemed as suspicious.<sup>128</sup>
- The OIPRD held a public meeting in Thunder Bay as part of the systemic review of the policies, practices and attitudes of TBPS as they relate to Indigenous death and missing persons investigations.
- Following a 911 call, police officers and Thunder Bay Fire Rescue rescued a man found floating and unconscious in the Neebing-McIntyre Floodway.<sup>129</sup>
- Weagamow First Nation, Fort William First Nation, the City of Thunder Bay and TBPS signed a formal friendship agreement. A TBPS media release said, "Signatories to the agreement hope to promote and cooperate in the areas of community development, public safety, anti-racism, education and social and cultural awareness."<sup>130</sup>

## October 2017

- Responding to a call that a body was floating in the river, Thunder Bay police officers rescued a woman from the McIntyre River.<sup>131</sup>
- TBPS officers rescued two teens from the Neebing River.<sup>132</sup>
- Statistics Canada released a report: "Aboriginal Peoples in Canada: Key results from the 2016 Census" that showed Indigenous people accounted for the highest proportion of the population in Thunder Bay, at 12.7 per cent. This represents an Indigenous population of 15,445. Statistics Canada measured Thunder Bay's census metropolitan area — the city (107,909) and its immediate surrounding municipalities — as having 121,621 people.<sup>133</sup>



## November 2017

- Charges against the man accused of throwing a trailer hitch from a vehicle that hit Barbara Kentner were upgraded from aggravated assault to second-degree murder. The case remains before the courts.<sup>134</sup>
- The Ontario Civilian Police Commission released the interim report of the Honourable Murray Sinclair's investigation into TBPSB. The report set out some specific issues that were under consideration for inclusion in the final report.<sup>135</sup>
- Following a coroner's investigation that involved the York Regional Police, no charges were laid in the deaths of Tammy Keeash and Josiah Begg.<sup>136</sup>

## December 2017

- Community hearings for the National Inquiry into Missing and Murdered Indigenous Women and Girls were held in Thunder Bay.
- TBPSB swore in an Indigenous board member.
- TBPS launched "Shaping our Future," an organizational change project to "re-right relations inside and outside TBPS (particularly with Indigenous groups) to respond to calls of systemic discrimination within TBPS." TBPS engaged a consultant from Lakehead University, Department of Aboriginal Education to lead the project. Areas for change included the Aboriginal Liaison Unit, recruitment, communication and training.<sup>137</sup>

## January 2018

- TBPS announced a call for Fort William First Nation artists to collaborate in designing an artwork display for the TBPS station.<sup>138</sup>

## February 2018

- Media reported that a TBPS use-of-force report presented to the police services board showed that in 2017, there were more than 50,000 interactions between police and residents of Thunder Bay, up nearly six per cent over 2016. Use-of-force incidents also rose from 62 in 2016 to 110 in 2017.<sup>139</sup>
- In two separate incidents, on the same night, Indigenous<sup>140</sup> pedestrians had eggs thrown at them from a passing car. TBPS opened investigations into both incidents and asked members of the public with information about either incident or who have had similar things happen to them to contact police.<sup>141</sup>



## March 2018

- A Thunder Bay newspaper, the Chronicle Journal published a front-page news article about eggs being thrown at two men under the headline “Egg-toss incidents have police scrambling.” The Assembly of First Nations said the headline was offensive and insensitive and called for an apology. The newspaper printed an apology saying “the play on words was inappropriate for a story about an alleged criminal attack and was inconsiderate, particularly to the victims in these attacks.” The Chronicle Journal apologized for the “poor choice of words.” The Assembly of First Nations Ontario Regional Chief told media that the Chronicle Journal rejected a request to discuss future coverage in an editorial board meeting.<sup>142</sup>
- The OIPRD completed its investigation into the conduct of TBPS officers involved in the investigation into the 2015 death of Stacy DeBungee. Subsequently, lawyers for First Nations leaders and the family of Stacy DeBungee publicly released the OIPRD’s Investigative Report that substantiated allegations of serious misconduct in the TBPS investigation. There is ongoing litigation concerning whether a disciplinary hearing will be held.

- A Thunder Bay police constable pled guilty to one count of Discreditable Conduct under the Police Services Act for posting Facebook comments about Indigenous people. The officer, who was ordered by an adjudicator to forfeit 40 hours, apologized to the Grand Chief of Nishnawbe Aski Nation, TBPS, the police services board and the citizens of Thunder Bay. As a penalty, the constable was required to forfeit 40 hours, which meant that he was required to work on his annual leave days or rest days until the hours were met.<sup>143</sup>

## April 2018

- The TBPS “Shaping our Future,” working group, which includes TBPS staff and three volunteer community members held their first meeting to work on the key goals of the project.<sup>144</sup>

The chronology provided in this chapter shows the historic and current events that impact negatively on the relationship between TBPS and Indigenous communities, as well as initiatives undertaken (a number of which followed the commencement of this systemic review) to attempt to improve the relationship.



# CHAPTER 3: COMMUNITY ENGAGEMENT



The systemic review team conducted over 80 meetings with community organizations, Indigenous leaders and organizations, service providers and the general public. The purpose of the meetings was to hear from both Indigenous and non-Indigenous people about their experiences with Thunder Bay Police Service's and their recommendations for change.

I am thankful for the time, participation and courage of those who spoke to us. For some participants, recounting their experiences meant reliving traumatic events. I am especially grateful to them for having the strength to come forward. In describing what my review team heard, I have endeavoured to protect the identity of participants.

The review team heard a broad range of views during the engagement sessions. However, consistent themes emerged from these sessions: most particularly, that many Indigenous people lack confidence in TBPS's work, including its ability to investigate Indigenous missing persons and deaths in an effective, bias-free way. They also identified the presence of systemic bias within TBPS, and often provided anecdotal information about discriminatory conduct by TBPS officers.

It was important for me to evaluate how the service is perceived within Indigenous communities. One measure of TBPS's success or lack thereof in its relationship with Indigenous communities is how it is perceived. It is critical to TBPS's success not only to ensure that its investigations and interactions are effective and bias-free, but that they are perceived as such.

## The Relationship between Indigenous People and TBPS

Overall, our meetings revealed nothing short of a crisis of trust afflicting the relationship between Indigenous people and TBPS. This crisis of trust was palpable at most of our meetings, whether the participants were youth, Elders, service providers, professionals or Indigenous leaders. It is evident that TBPS will need to work hard to advance reconciliation with Indigenous people, and that this journey will be a long one.

"The issues with police and other government structures go back generations. There is distrust of police going back generations to the time when the RCMP took kids to residential schools."

"Indigenous kids learn negative things about and fear of police from birth, seeing police taking away a person, etc. Traditional sayings were: "If you do something bad, I'll call the police on you. It used to be the boogie man, now it's the police."

"I grew up on the reserve. We were taught that the boogie man would come and get you. It made the police scary too. Parents would think police would take you away for residential school or take your kids to CAS."

**Overall, our meetings revealed nothing short of a crisis of trust afflicting the relationship between Indigenous people and TBPS.**

“There are lots of stories about police and various incidents. It is hard to tell what is true and not true, but the kids believe the stories. The stories are part of the lexicon of the students. Indigenous culture is a story-telling culture, Stories take on great importance and become bigger than themselves. Stories spread like wildfire and escalate attitudes toward police. “The four horsemen of the apocalypse” is four rogue officers who go after Indigenous people to beat them up. This may be urban myth or there may be some grain of truth. The legend has been around for a decade.”

**“We have to find ways to come together. We have to find a common story. That’s the way in. If we can start to have a common story, then we can start to move forward, and not until then.”**

Past colonial policies do not in any way relieve TBPS of its obligation to earn the trust of Indigenous people; in fact it only creates a greater onus on TBPS to do so. Any police service must take the community it serves as it finds it and take the necessary measures to meet its unique needs. I accept the views of participants who feel that TBPS has failed to meet this challenge.

The crisis of trust was expressed in many ways. Participants spoke of their reluctance to report crime to police and/or their reluctance to complain about police mistreatment, fearing that they would not be taken seriously or that they could be subject to reprisals:

“There is a lack of trust. People are afraid to report things – maybe they are in poverty, maybe a sex trade worker, maybe they have a record and no one will take them seriously.”

“Many Indigenous women are not anxious to deal with police. There may be many reasons for that. They are often not involved with police. That is not their desire. They fear it’ll make it worse for them.”

“We push people to call the police but the pushback is that the police don’t do investigations. Community members have a responsibility to report.”

Two legal workers discussed how the fear of calling the police for assistance has far-reaching impacts on Indigenous communities’ sense of safety and security:

“When your personal experience has led you to making a logical choice to not deal with police, reporting crime becomes too hard.”

“Cannot overstate the importance of police in society. There is an impact on people who fear using police: underreporting. What do you do if you can’t call police? It changes the whole nature of society.”



The issue of public safety and gangs, another challenge facing TBPS, also came up repeatedly in our consultations.

“A student told me she was in the Oddfellows building on May Street with other girls. They were duct-taped and tied up. She said she saw another girl from [her First Nation] in the building. Two days later that same girl was found dead in a back alley. There was no media. That was never reported. She was found on the street and it never made the news.”

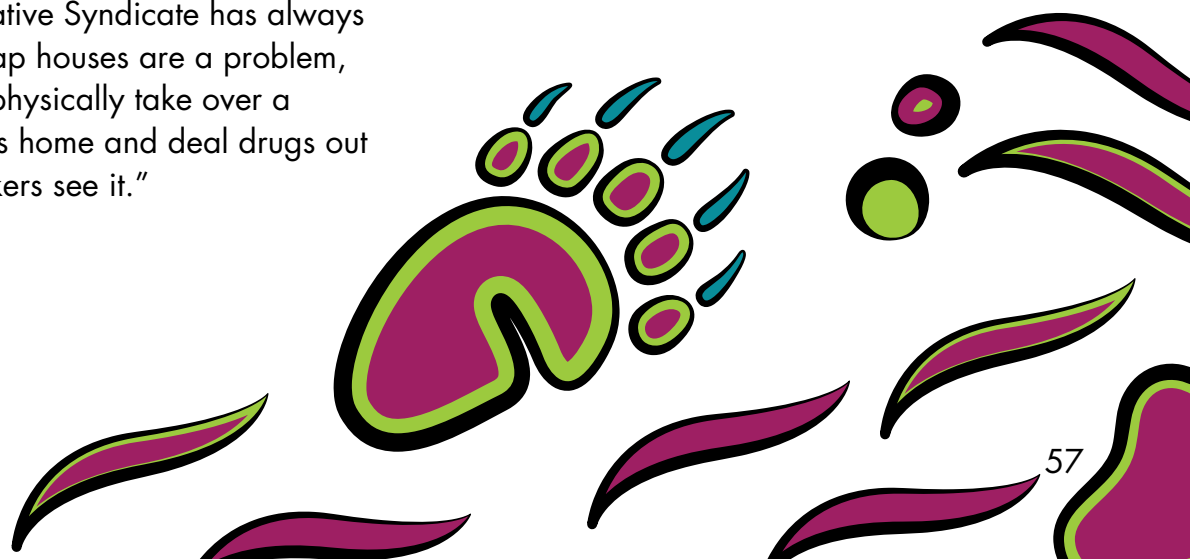
“[A member of a northern First Nation] said his niece had been missing for two weeks. His sister called and said that she thinks she’s in the Oddfellows building. He went to look. There was a guard on each floor. He saw her on the second floor and she was “out of it.” The guard stopped him and said he can’t take her and had to leave. They asked the police to go look and they called back and said the building was clean. Eventually the niece got out of the building. It was found that she owed a \$2,000 drug debt and was working to pay it off.’

“With young moms, gangs are preying on them. [Service providers] become involved. Around 2014, gangs from Ottawa and Toronto became the main gangs. The Native Syndicate has always been there. Trap houses are a problem, where gangs physically take over a young mother’s home and deal drugs out of it. Our workers see it.”

## Interactions with Individual TBPS Officers

The review heard a disturbing pattern of negative and discriminatory interactions between TBPS officers and Indigenous people. These encounters ranged from allegations of serious assaults to insensitive or unprofessional behaviour. We heard both from individuals who were the subject of these interactions, and persons who witnessed them. The witnesses to these events were both Indigenous and non-Indigenous. The majority of the incidents were recent; however, some went back decades and it was obvious to our team that they had caused lasting damage.

“Back in 1988 when I was in college, I was standing on the corner of Victoria and May with my young buddies. I saw a young Nish couple staggering into the back alley. Then police stopped – young cops. And they get out of the cruiser and walk back into the back alley and follow them. And we didn’t think much of it. The police came out maybe five minutes later and left. Then maybe another five minutes, that couple came out. They beat the shit out of that young boy. And we didn’t know what to do.”



Many of the incidents we heard about involved young people. Youth spoke of their frustration about the lack of recourse and accountability arising from these incidents:

"A few months ago, a few of the youth in Limbrick had been drinking. I witnessed this. A fight broke out and police came up. They didn't announce themselves. The officer was smiling as he pepper sprayed them. I got it in my eyes too. They wouldn't give us their badge numbers. Four or five adults came out and asked them to (provide their names). There was no incident number. No one phoned back when we tried to complain."

"I called the police on my son. He was under the influence. He was taken into custody. When he went into custody, there was nothing wrong. He came out with a broken thumb. I told him there's a process we need to follow. He said, "Mom, I'm not filing a complaint, then I'll become a target."

Events such as these did not appear to be isolated incidents. One service provider spoke of excessive use of force against a vulnerable Indigenous man in crisis in the following terms:

"Recently, we had an incident here. A person was having a mental health crisis at 4:00 a.m. He heard a voice from the radio that was telling him to kill someone. He was non-violent. He was saying he did not want to go with police. The first officer punched him eight times in the face. The second officer hit him five times and then they moved him out of range of the camera. He was put in a cruiser and

taken to the hospital. It was excessive use of force and it made me reflect back on all the stories I've heard and wonder if they are true."

This incident from 2016 led to findings of misconduct against the two involved TBPS officers.<sup>145</sup>

Several participants described incidents where Indigenous people were placed in TBPS vehicles and either driven to remote locations, or where brakes were applied suddenly and repeatedly.

"I've been in Thunder Bay since I was a teenager. I was a boarding student. I come from Gull Bay. I am a mother and grandmother. Thunder Bay is racist. I went through incidents with friends by being abused physically by police. We were shoved in the paddy wagon as a kid. The top of our clothes would be touched. We would be flying around in there, banging into a friend, banging into each other. At first, you're laughing but then you are eventually bleeding."

"In 2016, a distant relative came here from Sioux Lookout to play in a hockey tournament. He was a young man, teenager. He was outgoing, doing well in school. He went out drinking and got picked up by police. Police took him for a ride and called him a dirty Indian. They were hitting the brakes repeatedly. He was handed over to the next shift who continued this. It traumatized him. When he went back home, his Dad said he was withdrawn."

“There should be cameras installed in the rear of cruisers. The youths say that officers start and stop the brakes so they are bouncing around in the back.”

“Someone I know was recently supposed to be dropped off at the Balmoral Station but the police drove him out of town. He didn’t know where he was and another officer picked him up.”

“I was doing a report for a client. There was one incident with police. He was panhandling on the street. Police were on his case, asking him to move. He moved and then he came back. They said, “Do you want to go for a ride?” He knew what that meant. They would drive him out and drop him off. A white van drove up from the Shelter House and asked the officers, “What business do you have here?” They rescued him.”

We also heard numerous accounts of insensitive treatment of Indigenous people that is suggestive of a police culture of racial discrimination. The following account by one participant is reflective of what we heard:

“A First Nations woman was on my porch. I opened the door. The woman had blood all over her face, looked like a broken nose. She said she got jumped and people took her beer. I asked if she wanted us to call an ambulance. She said yes. The police were first to arrive. The police asked, “What is she doing in your house?” They got her name and did a background check. She asked for water. Police said, “She doesn’t need water.” Police said, “I hope you will burn that cup after. You might get AIDS.” The

cop was normal talking to me. As soon as he was talking about the First Nations woman, he changed – like Dr. Jekyll and Mr. Hyde. The police said she was in (a mental health facility) before. The police drove her to the hospital, didn’t bother to wait for an ambulance. Would they have changed their attitude toward me if they had known that I’m half Ojibway?”

The impact of these interactions on public confidence cannot be overstated. Many participants spoke about their mistrust of TBPS, and their belief that the police treat Indigenous people differently than non-Indigenous people:

“I was a break and enter victim three or four years ago. When we made the call, there was an intruder in my house at 3 or 4 a.m. It took police 15 or 20 minutes to get there. I live in a marginalized area. Two officers, a staff sergeant and a constable showed up. I told them the person broke my door. They put her in the back [of the cruiser] and took her home. She was a non-Indigenous woman. They used their Aboriginal Liaison Officer to try to smooth things over. I called to say nothing was ever done, there was no charge. They sent the Aboriginal Liaison Officer over to speak with me over coffee in a coffee shop.”

“It only takes one police officer to do something wrong and that trust is gone. How many will it take to get that trust back?”

“Police seem to respond different to First Nations groups. Police react more harshly to First Nations youth.”

## Systemic Racism and Accountability

Concerns over systemic racism within TBPS were a recurrent theme in the engagement sessions.

“Police are seen by Indigenous people as approaching with the aim of conviction and to find something wrong. We know there are individual officers who are racist. What we don’t want is a systemic culture of racism in the police. We need to be looking at that culture. We need to find ways to identify those officers.”

There was a widespread perception that TBPS officers engaged in racial profiling of Indigenous people generally, and Indigenous youth specifically:

“Racial profiling takes place in Thunder Bay. Groups of First Nations kids are more likely to be considered a “gang” as opposed to a group of friends.”

“I am white passing. I know that. I’ll get told, “Get home safely.” That’s the difference between having brown skin and white skin. I want to acknowledge that there are good officers too. But who is there for them? What is in place for them to have things to be more supportive?”

“I witnessed a young Indigenous person shackled and walked from this building to the courthouse. I thought: would they have done this to a non-Indigenous person? It made me sad. He was a spectacle. The officers made eye contact with me. It was like normalizing it, He was walking through the street, in shackles, over the snowbank. He was walking through the mall lobby and the whole parking lot.”

In a similar vein, many participants perceived disparities in the responsiveness of TBPS to calls for service:

“Officers get burned out. They are used to the same people and wouldn’t want to come. When I was Executive Director at the Shelter House, we would stop giving names at the Shelter House when we called police. They would pick up the client and drop them off a block away.”

“When Kashechewan was evacuated, we were one of the first hotels to put people up. There were a lot of issues then. We had a pregnant First Nations clerk at the time. An officer came and said, “You can call us but we aren’t coming here anymore. You rent to “these” people. That’s what you get.”



Most troubling, was the perception that these disparities occurred with respect to calls for emergency assistance:

"We call 911. The first question usually asked is, "Is it a native or a Caucasian?" Second question, "Are they intoxicated?" We will call them. It might be an hour later. We will see them drive through our parking lot and they won't come in, nothing."

"Police in Thunder Bay get a call. They get CPIC and see previous incidents and determine priority. Maybe that's why there's a slow response when Aboriginal people call 911."

Given the variety of concerns expressed by participants, the need for enhanced accountability was frequently a topic of discussion.

Many people discussed the need to identify officers who exhibit racist or discriminatory behavior and to hold them to account:

"Can't be a lip service process. We need to know how people are held accountable. Racism in TBPS started somewhere. We want to find out where and why and then change that."

"When you have police officers who think they can get away with anything, nothing will happen to them. That speaks to the police chief and the police services board not keeping the service accountable."

"You can't have bad employees ruin the reputation of a whole agency. Police should consider the same regarding their bad apples and deal with them. I think they know who they are."

Participants also discussed the need for TBPS to acknowledge that systemic racism exists within its institution in order to move forward:

"TBPS news releases make Indigenous people feel they want to stand away. TBPS communications seems to blame rather than show open accountability. They need to apologize with sincerity and with outcomes."

**"Police have a particular resistance to admitting racism. There is an attitude of denial. You don't deny the sky is blue."**

"They (TBPS) need to acknowledge the wrongdoings and apologize to move forward. Do it (apologize) in a central area in Thunder Bay like City Hall. Have a podium and have community be able to go up and speak about their experiences and worries...They would need to take accountability for their actions. That is the only way where they can start building that relationship again by actually acknowledging them and letting people talk and can give them a piece of their mind and actually listen because they do have responsibility for what they've done."



## Cultural Competency and Training

Many participants spoke of a need for TBPS to implement effective cultural competency training with respect to Indigenous people. There was a significant degree of skepticism about the efforts TBPS has engaged in thus far to address this gap:

“There needs to be cultural understanding more than cultural training. And how do they conduct their training?”

“The police training is Mohawk-based training. It is not productive when you’re in a city that’s predominantly Cree/Ojibway.”

**Participants emphasized that the training needs to be Indigenous-specific, and tailored to the specific circumstances of Indigenous communities in Thunder Bay.**

“Who chooses the training? What does it entail? Are they collaborating with organizations? I would like to see the Seven Grandfather Teachings as part of training. They also need mental health training and first aid training.”

“Anti-racism and anti-oppression training needs to be separate from Indigenous training. Don’t talk about new Canadians/refugees and Indigenous in this same way. Can’t approach it in the same way. You can’t “welcome” Indigenous people.”

“The biggest mistake is saying at a government level, “This is the training.” It needs to be locally determined with guidance from the local community working together, not from top down from people who want to put parameters around training.”

We heard that cultural competency training needed to be community-based and part of a broader range of measures in order to prepare TBPS officers to effectively serve Indigenous communities:

“Education can help with a holistic approach to dealing with First Nations.”

I had a meeting with the [police] chief to discuss ways to improve the situation. I looked at trauma-informed police services, this means participating in Indigenous community activities. They can’t just take cultural competency training and check a box. They have to do things differently.

“Education training from the Indigenous community needs to be taken seriously.”

Later in this report, I will offer recommendations to address many of these concerns.



## The Effectiveness of the Aboriginal Liaison Unit

TBPS's Aboriginal Liaison Unit (ALU) has a mandate to develop and maintain positive relationships between TBPS and Indigenous communities. Not surprisingly, the work of the ALU was discussed at our engagements. There were positive impressions of the ALU among some participants, accompanied by concerns about the level of resources allocated by TBPS as well as its limited role:

"As far as policing, they are spread thin. The education component becomes second to dealing with situations and that impacts the relationship. TBPS said they are looking at cutting them (liaison officers) back. They do an incredible job and are overspent. We encourage Indigenous parents to call them but they don't get call backs so they give up. They should be in high school (liaison officers). People in the roles are excellent but there is turnover because they are burnt out. There is no education anymore"

"The Aboriginal Liaison Unit used to have two (officers) on it, now one. We haven't met in years. It wasn't clear what the Aboriginal Liaison Unit's role was. I think it would be better if they would build trust and for investigations, bring people in. The role should coordinate meetings to see how to better provide service. What will make you feel safe?"

Many participants were sharply critical of the ALU and raised their concerns that the structure of the ALU results in "tokenism":

"The Indigenous Liaison Unit is down to one officer. There needs to be more, not a token number."

"We always had that. We always had those two gentlemen, Larry Baxter and Barry, they did awesome. But I know they felt like tokens. I mean, it's just a Band-Aid. True change of anything, organization, family, starts at the leadership. We need to have our own, we need to have Anishinabek people in board levels and the government levels because they will always bring a perspective every day to address the need."

"They have Aboriginal Liaison officers who get burnt out. They are not working on criminal issues. They are the token and they play the issues down. At police presentations, they are the officers that come out."

I will be making recommendations concerning improvements to the ALU to address some of these criticisms.

## Resistance to the Indigenous Peoples Court

The Indigenous Peoples Court (IPC) at the Thunder Bay Courthouse was officially opened in March 2017.

The coordinator of the IPC provided an overview of the court during the opening celebrations:

“The Indigenous Peoples’ Court is a restorative justice approach using Indigenous culture and traditions for Indigenous people who have been charged with a criminal offence. It is designed to function in a holistic nature and is consistent with the medicine wheel teachings of the Indigenous people... It will provide support to assist the individual’s rehabilitation and reduce recidivism.”<sup>146</sup>

The coordinator also spoke to the hard work and dedication of community members required to establish the IPC:

“It took a lot of people to build the Indigenous Peoples’ Court. It was a community effort. It involved key justice stakeholders and community, and we have held many gatherings over the past 18 months to discuss the framework for developing the IPC. We have conducted research and gathered information from other similar courts in Canada and visited the First Nation courts in Brantford, Toronto and British Columbia.”<sup>147</sup>

One of the main focusses of the IPC is healing, which involves Indigenous Elders guiding the court process and working with families to achieve this.<sup>148</sup> However, several community stakeholders described an initial resistance by TBPS officers to the court:

“The IPC. We sat at the table with a lot of stakeholders and worked hard. We shed a lot of tears. Police were there last year and for over two years. At the court, we have four doors. They wanted lots of police for security – at all doors. They wanted to put the accused in shackles, for the safety of the people of the courtroom.”

“At the Indigenous Person’s Court for our first hearing, they decided they would have six officers inside. One beside the offender, one beside the judge, one by the crown, blocking the four doors. They were not friendly faces. After the judge left the room, there was eye rolling. The next hearing, the judge said, “We don’t need this heavy of a police presence.” As the hearing was going on, one officer was trying to hold back his laughter. Just looking at each other, disrespecting the process. The Circle is a sacred place. It’s the feeling of being the other, that’s how I felt all my life.”

“There was great resistance to it – the committee – it was the police that made it the hardest. They went on about security. There are no prisoner boxes. That was the big hold up getting this court going. There was a whole attitude of eye rolling. One of the police officers said, “What about the victim in all of this?” It’s a restorative justice approach. Police will talk quite crassly about the Indigenous victims. Police officers see Indigenous victims the same way they see Indigenous accused.”

The opening of the IPC and TBPS’s involvement with the IPC appeared to represent a missed opportunity to improve its relationship with Indigenous communities.



## Community Policing

While a vast majority of participants in the review's engagement sessions provided critical commentary about TBPS, they also spoke about what steps TBPS could take to improve its relationship with Indigenous communities. In particular, many community members and social service providers discussed the need for TBPS to take a more community-centred approach to policing:

"We need officers and not just liaison officers to attend Pow Wows. When police have a good relationship with people, they can solve crime because people on the street know what is going on."

**"The police role is huge in the community. It's not just responding to crime, it is prevention in the neighborhoods – community policing. They should set this up as a committee to outreach to the community."**

"I also see police walking around on the street, interacting. It is more positive and improves the relationship."

Indigenous youth shared similar sentiments with respect to the importance of community policing in order to enhance communication and relationships:

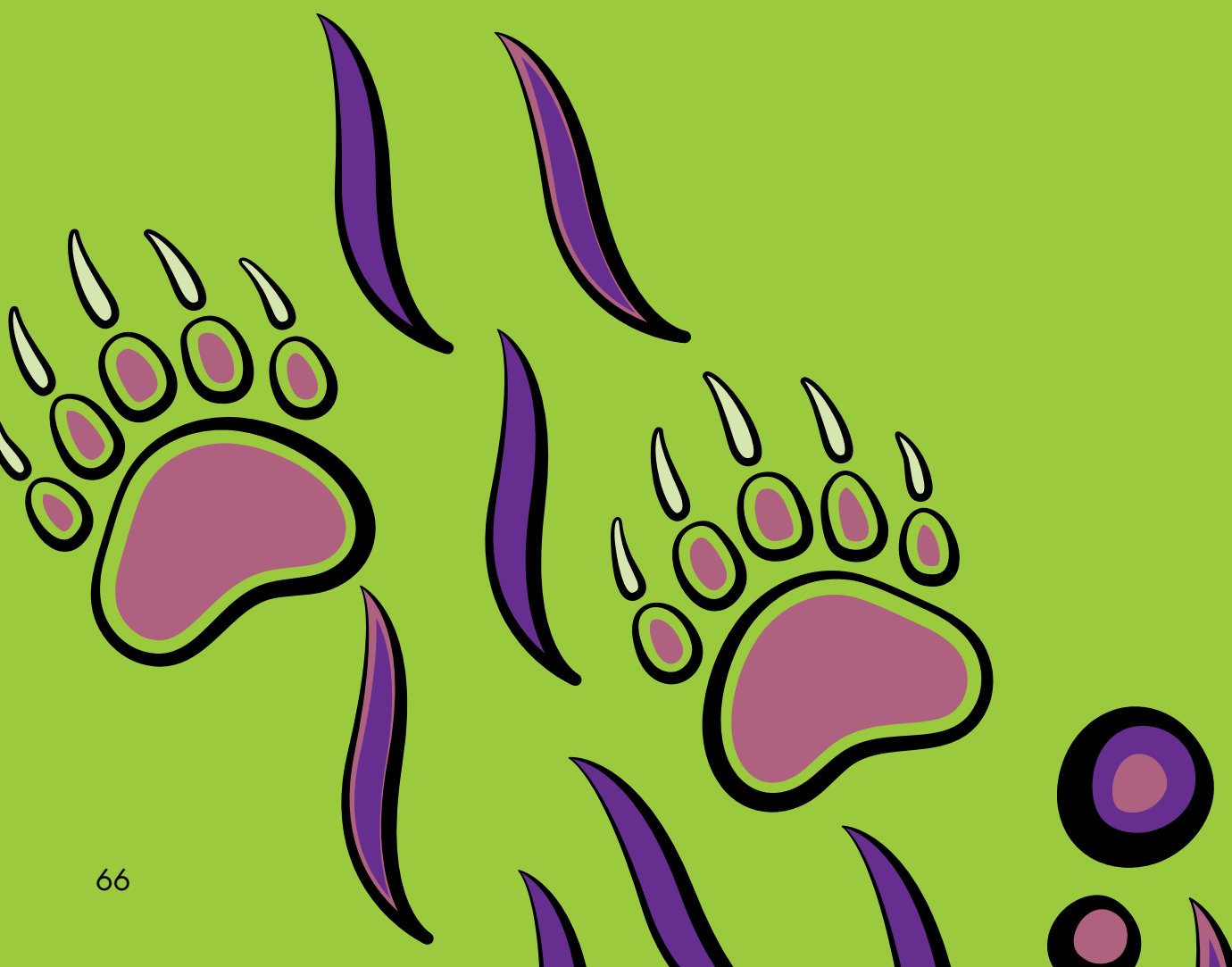
"Officers should develop a relationship. They don't know us on a personal level. They don't know our stories. They don't see us as humans. Maybe if they see that we have things in common, come to our functions; have officers that want to get to know the youth. If so, maybe youth wouldn't run away and listen to what's going on."

"Two police came to the community kitchen and cut up vegetables and talked to us. We need more of those types of police. We fear police right now. It's rooted in us from childhood. Children in Limbrick are starting to be scared when we have the mentality of us versus them. They are supposed to work for us, not against us."

What came through in our consultation was that community members aspire to a healthier and more respectful relationship with the police.



# CHAPTER 4: SUBMISSIONS FROM COMMUNITY ORGANIZATIONS



The OIPRD received several submissions from community organizations, which are summarized in this chapter.

## Aboriginal Legal Services

Aboriginal Legal Services (ALS) operates legal-related programs for Indigenous people in Toronto and elsewhere in Ontario. ALS assists clients in areas such as police complaints, victim's rights, human rights, tenant rights, criminal injuries compensation, inquests, Indian Act matters, Canada Pension Disability applications and Ontario Works and Ontario Disability Support programs. ALS represented six of the seven families at the Coroner's Inquest into the Deaths of Seven First Nations Youths.

ALS submitted that the historical role police played in connection with Indigenous people continues to affect the relationship between police and Indigenous communities in two ways. First, the historical relationship created an underlying barrier to communication and trust when police were used to remove children, break up families and resolve Indigenous rights and land disputes. That historic fear and mistrust continues today. Second, Indigenous people are subjected to under-policing, where police do not act on reported crimes despite evidence supporting the conclusion that a crime has been committed. ALS contends that under-policing is driven by racism, false assumptions and stereotyping.

ALS called on the OIPRD to adopt the recommendations in the Coroner's Inquest into the Deaths of Seven First Nations Youths regarding missing persons investigations and searches. ALS recommended that TBPS

improve the tools it has to communicate with Indigenous families, communities and leaders and create new initiatives to build positive connections. ALS submitted that TBPS should work to increase the number of Indigenous officers and TBPSB should have Indigenous representation. (One Indigenous board member was since appointed.)

## Multicultural Association of Northwestern Ontario

The Multicultural Association of Northwestern Ontario (MANWO) and its youth wing, the Regional Multicultural Youth Council (RMYC) provided a 100-page submission outlining some of the work they have been doing with Indigenous students, including students from Dennis Franklin Cromarty High School and with TBPS on various community projects going back to the 1990s.

MANWO/RMYC stated that concerns about racism are common and predominantly affect Indigenous people. The various surveys they have conducted reveal tensions between TBPS and youth. The submission referred to the detention and questioning of an Indigenous student based on ignorance over the type of clothing the student was wearing. The submission also referenced a 2003 incident where an intoxicated Indigenous man was picked up by police and driven to the Mission Island marsh outskirts of Thunder Bay and left there. The officer received a demotion after he pled guilty to a discreditable conduct charge. The submission noted that such incidents are well-remembered in Thunder Bay and across the region.

In its analytical observations comparing 2008 to 2011, RMYC noted that problems involving public intoxication, drug dealing, drug abuse, loitering, assaults, muggings, gangs, robberies and crime in general had increased. The Neighbourhood Police offices that were in high-risk areas in 2008 were gone in 2011; the Neighbourhood Watch program was also dismantled. In 2011, there were a higher number of incidents where spoons, raw eggs and other objects were thrown at sex trade workers. This prompted TBPS to open a specific occurrence file to report incidents where objects had been thrown by people from moving vehicles.

In its submission, MANWO/RMYC provided a Thunder Bay Neighbourhood Survey report that was completed in 2011, after the council visited eight Thunder Bay neighbourhoods to talk to youth about safety concerns. It was a follow-up to a survey conducted in 2008. The report included recommendations for an action plan. Some recommendations that involved police and policing included:

- There is a common belief in impoverished neighbourhoods that they are not policed or protected the same way as wealthier areas. Racial minorities and Aboriginal people also feel that they are victims of racial profiling and stereotyping by prejudiced police officers. The City and TBPS should re-establish Neighbourhood Policing Offices in high risk community housing complexes. Sharing space in local neighbourhoods brings people and police officers closer and gives them a chance to learn about diversity and be culturally sensitive.

- The City should support the establishment of a youth resource centre conveniently located for easy access and open 24/7 as a safe place for all youths to hang out.
- The City should develop ways to monitor the racial climate in neighbourhoods and engage the general public to deal with the racial divide between Aboriginal and non-Aboriginal people. Racism is a two-way street. In the absence of enlightened interaction and mutual understanding to counter ignorance and the perceptions that feed stereotypes, prejudice and discrimination, the power dynamics favour perpetrators. Letters to the editor in the local press reveal a polarization of attitudes and hardened beliefs.
- TBPS should invest in a public relations campaign to promote fairness, equity and inclusive treatment of all citizens including children and all youths across the city.
- The police service should continue their effort to recruit police officers from the Aboriginal community, racial minorities and women to reflect our diversity and improve the lines of communication with marginalized groups.



## Office of the Provincial Advocate for Children and Youth, Feathers of Hope

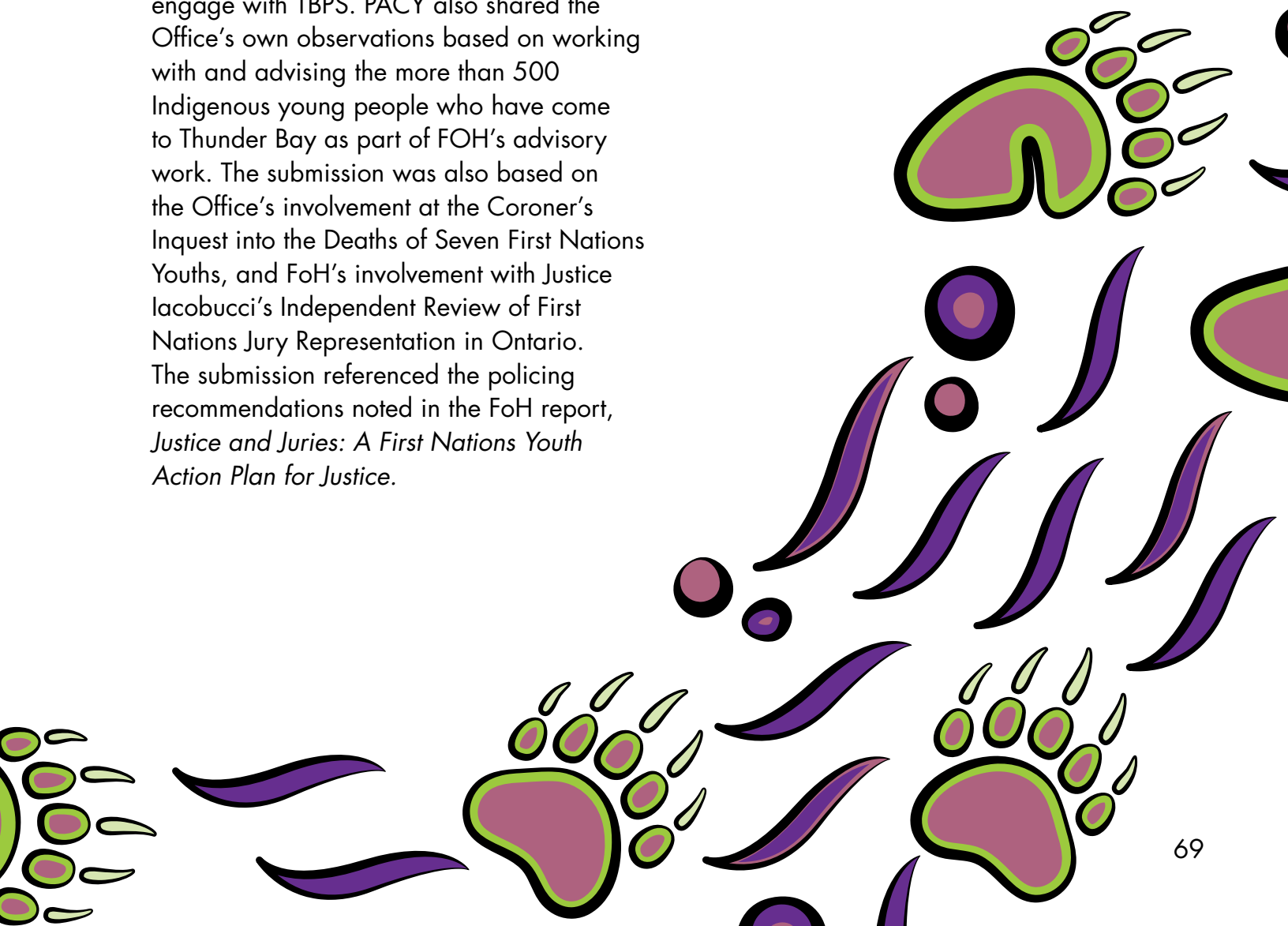
The Office of the Provincial Advocate for Children and Youth (PACY) provides an independent voice for children and youth by, among other things, partnering with them to bring issues forward.

PACY provided a submission informed by young people from its Feathers of Hope (FoH) group. This group met with the OIPRD in April 2017 and again in April 2018.

PACY submitted that the prime focus of the FoH submission was to highlight the “lived reality” of Indigenous young people who engage with TBPS. PACY also shared the Office’s own observations based on working with and advising the more than 500 Indigenous young people who have come to Thunder Bay as part of FOH’s advisory work. The submission was also based on the Office’s involvement at the Coroner’s Inquest into the Deaths of Seven First Nations Youths, and FoH’s involvement with Justice Iacobucci’s Independent Review of First Nations Jury Representation in Ontario. The submission referenced the policing recommendations noted in the FoH report, *Justice and Juries: A First Nations Youth Action Plan for Justice*.

The submission stated that the issues faced by Indigenous people in Thunder Bay are multifaceted and the culture that exists is often described as adversarial and oppressive. Overall, the primary concern shared by FoH was the poor relationship between policing and Indigenous communities, and what they experienced as a lack of respect and knowledge by many police officers engaged with Indigenous communities. The submission stated:

If this is to change, it is our strong view that expectations must be clear, timelines must be set, and accountability and monitoring must be attached to every recommendation made by the OIPRD.

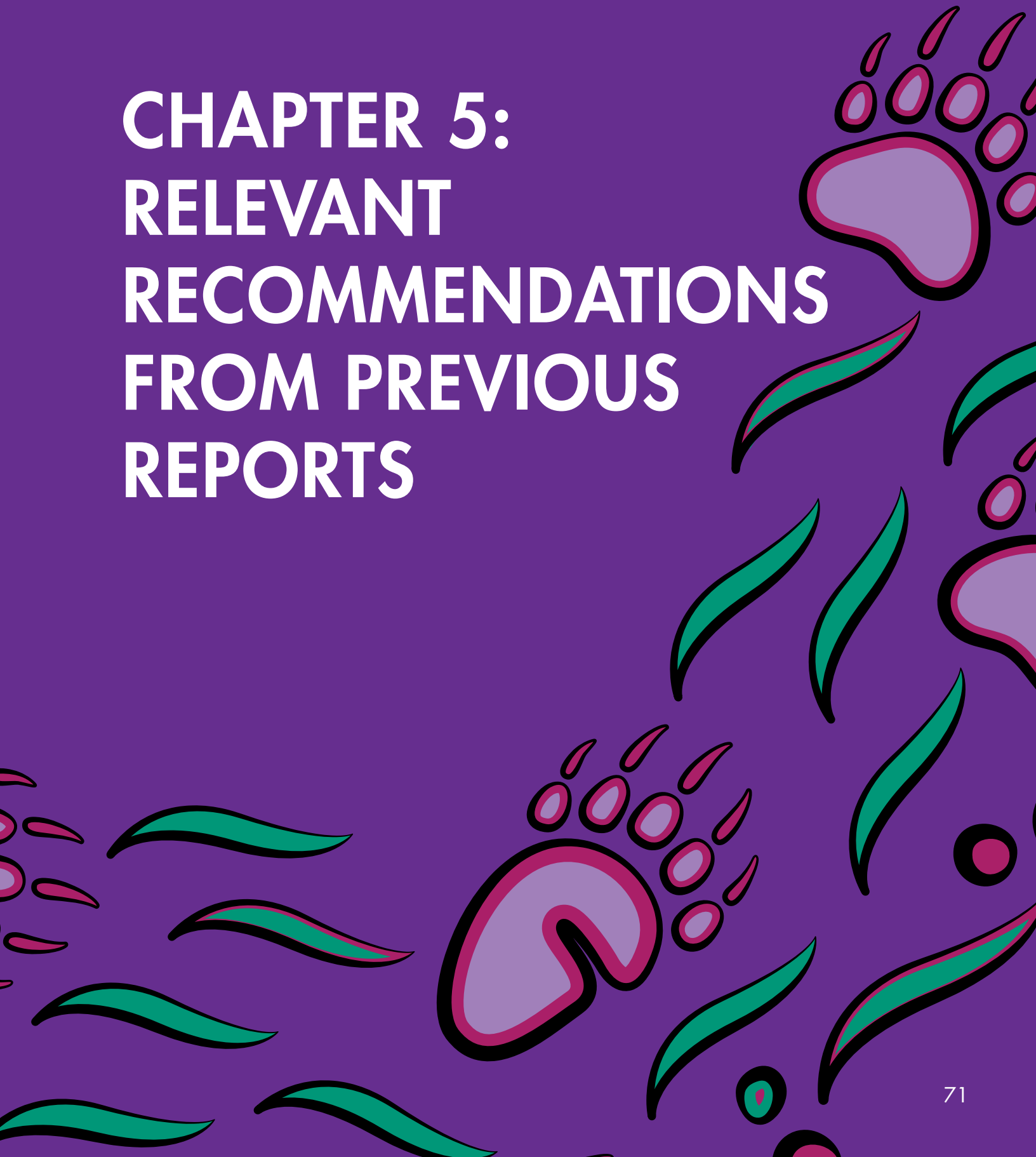


The Office of the Provincial Advocate for Children and Youth and FoH made recommendations on missing persons and death investigations, training for officers, community relations, safety, the number of Indigenous officers in TBPS, the Thunder Bay Police Services Board and the OIPRD. Notable recommendations included:

- Using the Uniform Missing Persons Act, <sup>149</sup> Ontario must move quickly to pass Missing Persons legislation that provides clear regulations and directives tied to how all municipal, provincial and Indigenous police missing persons investigations must be conducted.
- There is an immediate need for increased opportunities for TBPS officers and civilian employees to partner with NAPS staff around job shadowing and joint training so that conversations and the sharing of lived experiences in policing can be used as learning and transformative opportunities.
- TBPS, as part of its community outreach and education efforts, reach out to the First Nation communities and hire young Indigenous students through the Youth in Policing Initiative.
- Make it a mandatory requirement that all officers must wear body cameras at all times they are on duty.
- Create an online and media driven strategy that will broaden the conversation of cultural safety within and beyond TBPS.
- That the OIPRD host follow-up meetings with community members to talk about over-and under-policing concerns once it releases its report. A community gathering at 12 months, 24 months and 36 months that would align with monitoring and evaluation would be ideal.



# CHAPTER 5: RELEVANT RECOMMENDATIONS FROM PREVIOUS REPORTS



This systemic review is certainly not the first examination of Thunder Bay Police Service's relationship with Indigenous communities. This review considered a number of prior reports related to this topic, and recommendations contained in those reports. This section of the report summarizes key components of prior reports.

## The Report of the Race Relations and Policing Task Force (1989)

In 1988, a task force led by retired Judge and former Ombudsman Clare Lewis Q.C., was established by the Solicitor General of Ontario "to address promptly the very serious concerns of visible minorities respecting the interaction of the police community with their own."<sup>150</sup>

The task force heard oral presentations in Ottawa, Windsor and Thunder Bay. In Thunder Bay, 14 presentations were made to the task force, including one from TBPS.<sup>151</sup>

During a presentation, a spokesperson for the Ontario Native Women's Association explained to the task force that nine members of her family died violently but charges were not forthcoming. Her belief was that "every one of those cases I'm talking about has been passed off as natural death" and that "police consider solving crimes against native people a low priority and don't make a strong effort to catch those responsible."<sup>152</sup>

Speaking generally about the treatment of Indigenous people by police, the task force made the following observations:

"The submissions by native peoples were devastating in their statements of despair and of powerlessness in the face of the whole of the justice system. The native peoples perceive over-policing of trivial conduct by them which may be seen as a nuisance by the white community. They perceive under-policing of serious offences within the native communities in which natives are themselves the victims of native crime. The native peoples argue, with conviction, that they are viewed stereotypically by the police with terribly negative results."<sup>153</sup>

The task force declined to make specific recommendations to address racism in the delivery of police services to Indigenous people based on its lack of mandate, expertise, time and Indigenous representation. However, the task force did recommend the creation of a forum to "fully address issues of criminal justice in this province" in relation to Indigenous people.<sup>154</sup>





# A Community of Acceptance: Respect for Thunder Bay's Diversity (2002)

In 2002, a consultant was retained by Diversity Thunder Bay to conduct a study of race relations generally in Thunder Bay. The study identified police as "one of the top social locations where racism occurred in Thunder Bay".<sup>155</sup>

The study made troubling findings about how study participants viewed TBPS officers and their conduct. Included in the findings were:

"...racialized individuals report with distaste that the stereotyping overflows into the direct way that they experience being treated by the police. Furthermore, there is evidence that there are strongly racialized views within the police force."

"Aboriginal peoples perceive that most of the police racism is directed at them, including, occasionally, a sense that the police are to serve the white community, not Aboriginal peoples."

"A number of respondents mentioned racial comments, safety concerns and violence associated with being a racialized person in contact with police services... Reports of past and possibly present beatings, forced undressing, and other incidents of abuse still circulate."

"Aboriginal peoples reported that police officers treated them as if they were all drunks, dishonest, or troublemakers. This leads to treatment that differs from the treatment that white people receive."

"Several people mentioned that they perceived the police as more likely to jail an Aboriginal involved in a fight than the white co-combatant. Other study participants believe police are rougher with racialized people than with whites."

"...several interview participants mentioned a number of racialized comments or attitudes that may indicate an organizational culture that accepts and does not question such attitudes. An example would be tolerance of comments about "drunk Indians" as several participants noted they had overheard."<sup>156</sup>

The study observed that "courageous leadership from the ranks would be needed to make Thunder Bay's police forces a safe place for both racialized employees and citizens." The study recommended "diversity training", improved training more generally, and the recruitment of Indigenous police officers.<sup>157</sup> Significantly, the study asked TBPS to "[s]top racial profiling."<sup>158</sup>



# Thunder Bay Police Service: Analysis of Policy and Procedure Manual (2007)

In 2006, TBPS, together with the Thunder Bay Multicultural Association, retained a consultant with the limited mandate of reviewing TBPS's Policy and Procedure Manual. The objectives of reviewing TBPS's policies, practices and procedures were to "ensure their inclusiveness and respectful wording, providing recommendations for change if required with examples of policy wording and best practices from other jurisdictions" and to "conduct an overview of policies and practices in other policing jurisdictions regarding diversity."<sup>159</sup>

The report found that TBPS's written policy manual was appropriate but identified some areas for improvement. These included changes to the code of conduct, the complaints policy and human resources policy.<sup>160</sup>

# Diversity in Policing Project

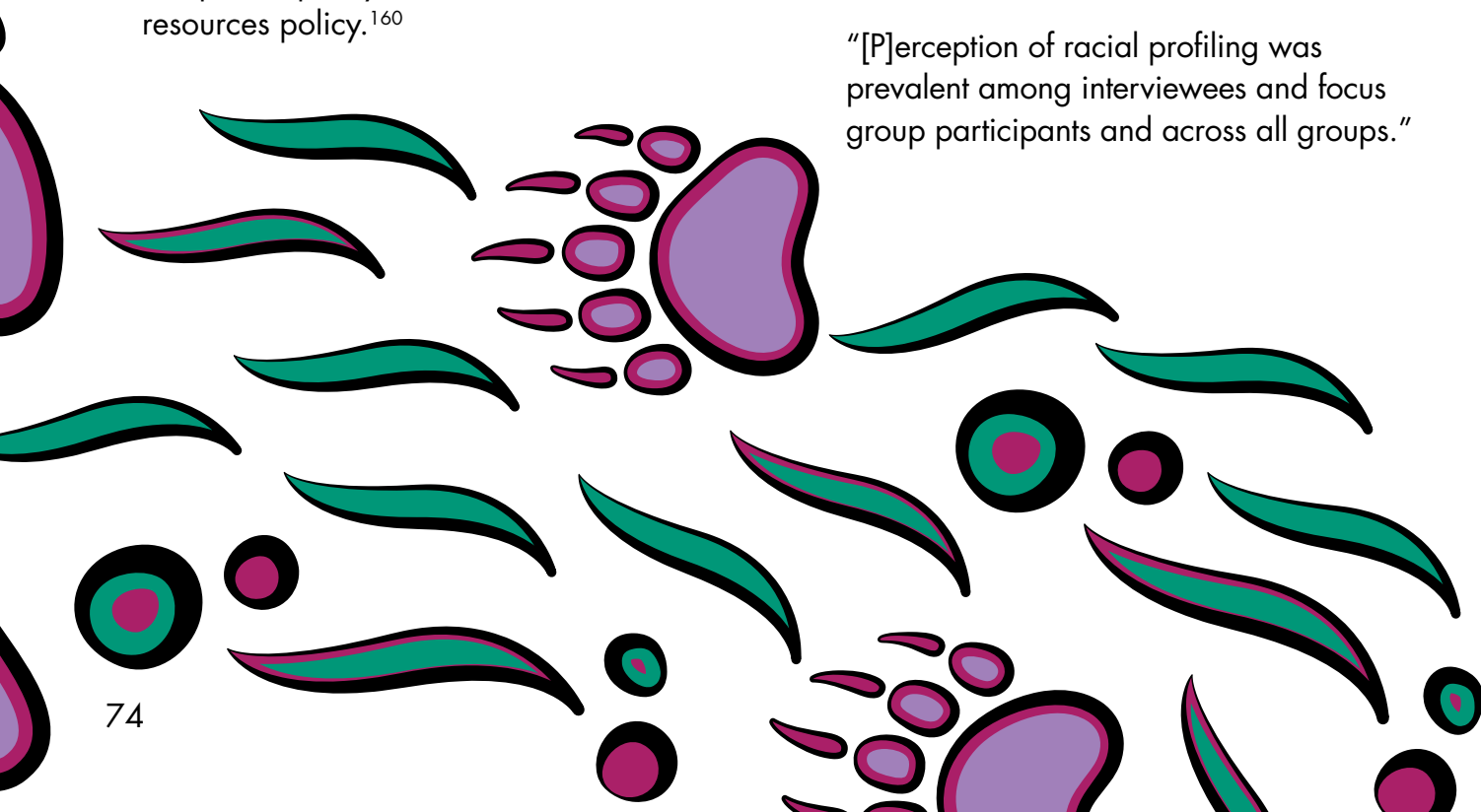
## Phase I Report (2007)

In response to the findings of the **A Community of Acceptance** report and other reports, Diversity Thunder Bay, the Thunder Bay Multicultural Association, the Thunder Bay Indigenous Friendship Centre, and TBPS initiated a project to identify and reduce systemic racism in policing. The project was funded by Heritage Canada from January 2004 until March 2008.<sup>161</sup>

The project's consultations included 50 key informant interviews and 23 focus groups, comprised of 155 community members. The majority of those consulted were Indigenous.<sup>162</sup> The project's findings were consistent with those of previous reports:

"For every focus group, reports of respondents' bad encounters with police outnumbered good encounters."

"[P]erception of racial profiling was prevalent among interviewees and focus group participants and across all groups."



“Recruitment practices needed work to attract a broad cross-section of candidates and to create a more welcoming climate for Aboriginal peoples and visible minority members; and, there were gaps in recruitment and retention practices.”

“TBPS do not offer courses related to diversity issues; and there is little embedded diversity training in existing courses.”<sup>163</sup>

It was contemplated that there would be a Phase II to the project. Phase II was to have addressed recruitment, policy review, learning and dissemination. The project was to be evaluated after four years, through measuring (among other things) TBPS membership’s attitudes and beliefs, perceptions of the racialized communities about racial profiling, changes in recruitment, and selection and promotion of employees to better reflect the community served.<sup>164</sup>

### Final Evaluation (Spring 2008)

The review met with Dr. Leisa Desmoulins to discuss the Diversity in Policing Project and TBPS’s current initiatives. Dr. Desmoulins believed that the project “had momentum because of the people around the table,” which included senior police managers, Aboriginal liaison officers and staff level participants. According to Dr. Desmoulins, this momentum “ended when the grant ended and the project disbanded.”<sup>165</sup> Dr. Desmoulins’ evaluation of TBPS’s implementation of the diversity initiatives disclosed that approximately half of the project’s recommendations were implemented as of the spring of 2008.<sup>166</sup>

## Thunder Bay Committee against Racism and Discrimination: A Report on the Thunder Bay Plan for Action (2009)

In 2009, the Thunder Bay Committee against Racism released its Plan for Action following a year-long community-based research project. The Plan for Action made findings and recommendations across a number of areas, including policing services.<sup>167</sup>

The Plan for Action observed that TBPS had taken a number of steps to address racism within its institution between 2004 and 2008 through the Diversity in Policing Project, but that TBPS “...has not eliminated perceptions and persistence of racism in policing.”<sup>168</sup> It also noted that the Community Diversity Committee, a standing committee established by the TBPS police chief, had not met in the previous year.<sup>169</sup>

The Plan for Action recommended that TBPS better track police complaints of racial discrimination in order to identify racial profiling, as well as under-policing or over-policing in certain areas or neighbourhoods. It suggested that “Aboriginal and other racialized peoples are best positioned to assess the gaps and assess the success of initiatives,” and recommended that TBPS “ask Aboriginal and other racialized peoples their perceptions of racism...”<sup>170</sup>

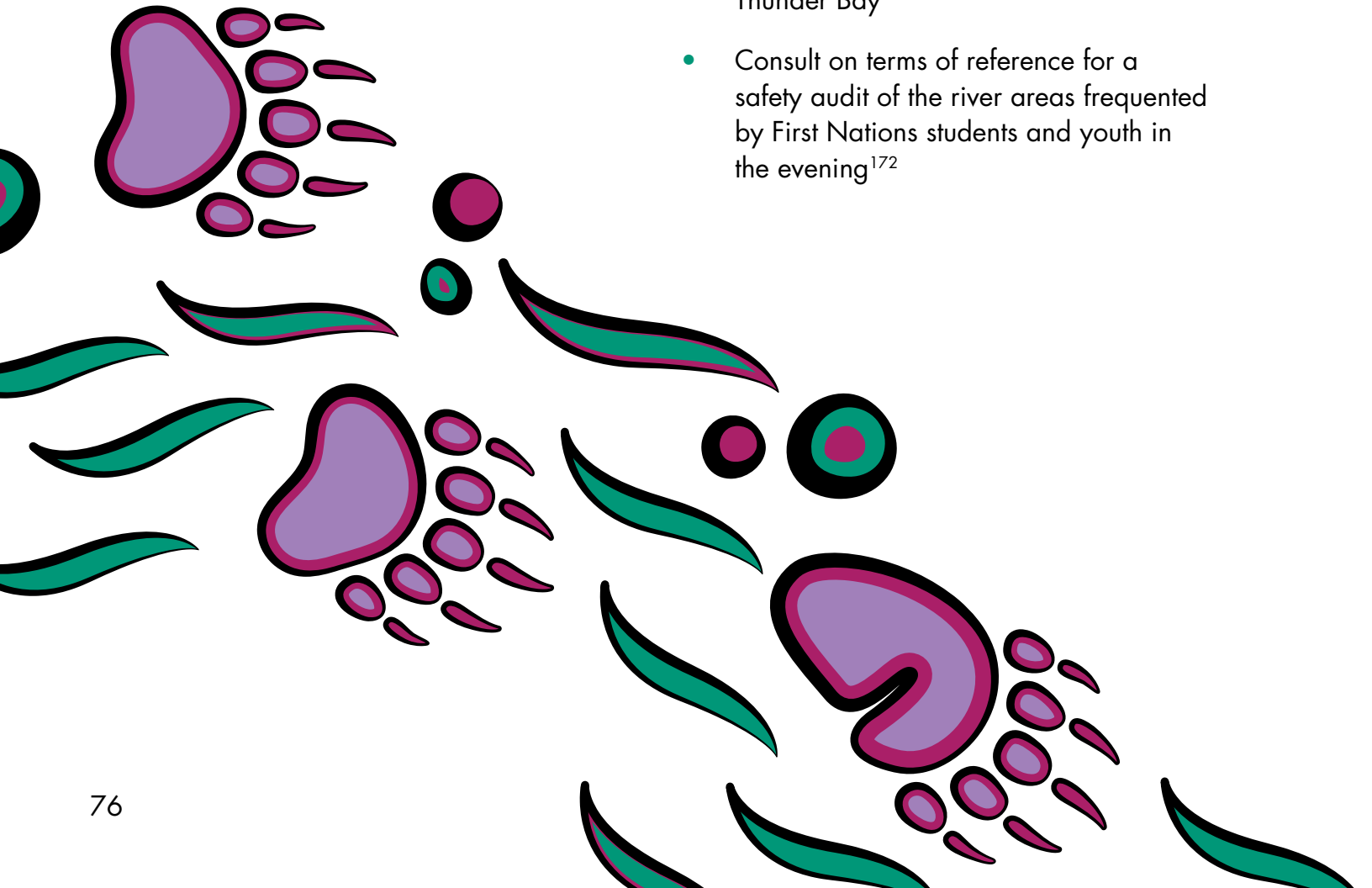
# Coroner's Inquest into the Deaths of Seven First Nations Youths (2016)

In 2015 and 2016, a lengthy coroner's inquest was held into the deaths of seven First Nations youth, all of whom died while attending secondary school in the city of Thunder Bay.<sup>171</sup>

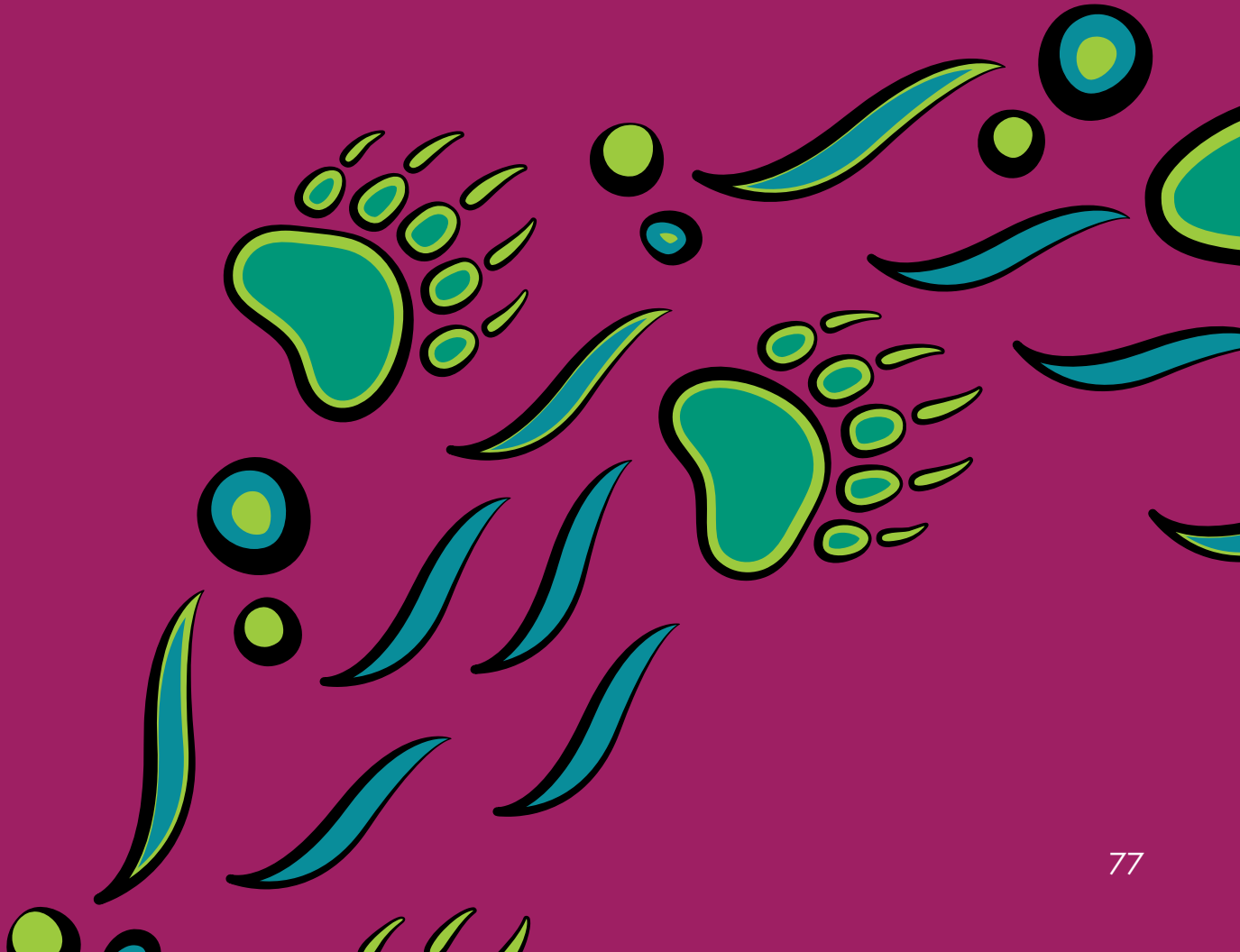
In each of the cases, TBPS was the investigating police service in respect of both the missing persons and/or sudden death investigations. Questions were raised in the course of the inquest regarding the quality of TBPS's investigations.

The inquest jury made 145 recommendations directed at various levels of government and institutions, including TBPS. The jury recommended, among other things, that TBPS:

- Participate in a working group to improve practices with respect to missing persons investigations into missing Indigenous youth
- Discuss approaches to news releases pertaining to any missing persons matter that involves a student
- Ensure that all of its members are trained on the 2016 missing persons policy
- Engage an external consultant to assist in revising current training modules to ensure that curriculum covers cultural issues that are relevant to members of the Indigenous community in and around Thunder Bay
- Consult on terms of reference for a safety audit of the river areas frequented by First Nations students and youth in the evening<sup>172</sup>



# CHAPTER 6: TBPS SUBMISSIONS



As part of this systemic review, the OIPRD received written submissions from Thunder Bay Police Service's in February 2017, January 2018 and May 2018. This chapter provides a summary of those submissions along with direct quotes.

TBPS provided information and statistics on the city, its geography, population, demographics, police complaints, as well as the make-up of the police service and its interaction and cooperation with other police services in the area. TBPS also provided statistics on calls for service, crime rates, missing persons, sudden deaths and homicides. TBPS submitted that the service solved 23 of 25 homicides between 2009 and 2016.

In its submissions, TBPS stated that the service has, for some time, acknowledged that problems exist in its relationship with Indigenous communities. TBPS stated:

"It has been recognized by the Thunder Bay Police Service leadership as one of the foremost challenges faced by the service. As far back as 1995, with the implementation of the Aboriginal Liaison Unit, the service turned its mind to implementing strategies that would improve its relations with the Indigenous community. Since that time, the service has made meaningful improvements in these relationships and continues to do so. However, the service knows that more work needs to be done to continue building and improving this important relationship."

**In its submissions, TBPS stated that the service has, for some time, acknowledged that problems exist in its relationship with Indigenous communities.**

TBPS indicated the service is engaged in over 30 community initiatives and projects:

"The Thunder Bay Police Service is in many ways an advocate for the Indigenous community within Thunder Bay and the surrounding area. The service has shown its support for programs that go above and beyond the necessary requirements and mandate of a police service in order to fight against discrimination of Indigenous persons and to fight against the perception that the service discriminates on such a basis."

## Challenges in Policing and Community

TBPS submitted that Thunder Bay has become a regional services hub for Northwestern Ontario, and a statistically significant portion of the population are temporary residents or visitors. Many are Indigenous people coming from the First Nations of Robinson-Superior, Treaty 3 and Treaty 9 for various reasons, including access to employment, services and education. TBPS stated:

"It hoped to further demonstrate, through the course of the review and its submission that due to the unique environment of Thunder Bay, the police service faces issues not faced by other police services in the province or the country."

TBPS also submitted that many Indigenous people have a distrust of the police rooted in the historical context of broken treaties, the residential school experience and the "Sixties Scoop."

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

Citing the fact that TBPS has one of the highest rates of police presence per population of 100,000 in Canada, TBPS said that the resources required to maintain a large force over a large geographical area are quite extensive. On the other hand, it is unable to produce budgets equivalent to those in more populous jurisdictions. Hence its resources are stretched.

The service submitted the example of York Regional Police being asked by the coroner to assist TBPS with investigations into the deaths of Josiah Begg and Tammy Keeash. YRP spent three months, with six dedicated investigators, assigned to the two files. At any given time, five of them were in Thunder Bay. During the same time, TBPS Criminal Investigations Branch investigated four homicides, one attempted homicide and 135 missing persons reports, along with other criminal investigations into domestic assaults, sexual assaults and robberies. The Criminal Investigations Branch<sup>173</sup> is comprised of four detectives and eight detective constables. TBPS submitted:

"While York Regional Police's contribution to the investigation focused largely on interviewing witnesses, the conclusion reached were the same ones reached by TBPS at that point in the investigation."

The issue of policing coverage over a large geographic area was raised.

"Specifically in Thunder Bay, there is a large population with no fixed address and who, in some cases, fear the police. This fear of police, whether based on actual experience or preconceived and misconceived notions, impacts the ability of the police to perform their function. There is a population that feels itself unable to, or in some cases unwilling to, cooperate with police and assist in investigations. This may be the result of fear or cultural barriers and an inability on the part of the police service to regularly travel to northern reserves in search of witnesses and victims as part of the investigative process."

TBPS cited an example of an incident in 2008, in which it received information from Dennis Franklin Cromarty High School that a student had been approached by a group of youths who attempted to recruit him into their gang. When he refused, an altercation ensued and he was pushed into the river. However, the student managed to escape.

The TBPS officer who filed the report had copied his initial occurrence report to the Gang Unit because of the potential gang issue. TBPS tried to interview the student; however, he had withdrawn from DFC and returned to his home community and officers did not have his address. TBPS made efforts to have NAPS interview the youth but he did

not attend to be interviewed. TBPS stated that despite the assigned officer's persistence and concern, he faced many barriers in his investigation, ranging from communication issues to geographical challenges. The student was unwilling to cooperate and therefore, TBPS was unable to proceed with any meaningful investigation.

The submission stated:

"The police service is cognizant of the issues that exist as a result of the large geographical coverage area and the northern communities to which a witness, victim or accused may travel. It is for this reason that the service is beginning to look more closely at collaborative techniques with the First Nations police services and other First Nations organizations to close this gap."

## **TBPS Review of its own Investigations of Indigenous Individuals**

As part of the systemic review, the OIPRD asked TBPS to provide case investigation files for review. During the course of the systemic review, the OIPRD advised TBPS of some of the findings from the case reviews. TBPS undertook to also review some of its own case files. As a result, TBPS identified shortcomings in the investigations, as well as concerns regarding the thoroughness of the investigations. Some of the issues included the lack of formal interviews with witnesses, the lack of follow up on investigative leads, the lack of thoroughness in notes and the level of investigation. There were significant shortcomings. TBPS identified

significant shortcomings in two and indicated that it is continuing to review additional investigative files.

Mindful of the reaction to TBPS's early news release in connection with Stacy DeBungee's death, TBPS submitted that the service understands that the media release in relation to that investigation deeming DeBungee's death as "non-criminal," was premature and a reason for criticism and negative attention.

TBPS submitted that in sudden death and missing persons investigations its officers "are now exceeding their police duties by remaining sensitive and open to the traditional and cultural needs of the Indigenous community." The service stated that officers have made arrangements for families to attend the scene of a death, facilitate ceremonies and answer questions to assist with the healing process.

One senior Crown counsel described measures taken by investigators in one homicide case to explain in a sensitive and transparent way why the case was unlikely to result in conviction.





# Continuing Review of Policies and Procedures at TBPS

TBPS indicated that it regularly reviews its policies and programs. Some of the most recent reviews include the following:

## Sudden Death Policy Review

TBPS said the Sudden Death Policy was extensively reviewed and revised as of December 2016, and will be reviewed on a three-year basis. Sudden or unexplained deaths and found human remains will be considered potential homicides and undertaken in accordance with the TBPS Criminal Investigation Management Plan.

## Sudden Death Review Committee

TBPS said that it implemented a Sudden Death Review Committee in January 2017 to review all outstanding sudden deaths to ensure that all investigative requirements are fulfilled. The committee is comprised of the Deputy Chief of Police, the Criminal Investigations Branch Detective Inspector and Detective Sergeant and one other Inspector from another branch. The committee meets monthly to review all outstanding sudden deaths. The detective sergeant will be in charge of briefing the committee on the sudden deaths. The committee may also decide to meet for specific cases.

TBPS submitted that when a sudden death occurs, the case is added to a spreadsheet that is used to track all sudden deaths that TBPS has responded to. The Criminal

Investigations Branch assistant creates a folder for each sudden death with the Sudden Death Checklist, General Occurrence report, Identification report, The Criminal Investigations Branch report and any pertinent Supplementary Occurrence reports. The CIB detective sergeant reviews the investigations after the detectives. If the sergeant is satisfied that all necessary investigative steps have been taken, the file is passed along to the committee to re-evaluate and look for various issues, such as training and investigative issues. If the The Criminal Investigations Branch detective sergeant is not satisfied, the case is sent back to the detectives to conduct further investigation and fill in the gaps. This is also true if the committee is not satisfied with the investigation.

## Missing Persons Policy Review

TBPS said it completely revised its Missing Persons Policy, which came into effect in February 2016. TBPS acknowledged that the old policy was “not adequate regarding all missing persons cases.” The new policy takes into consideration the demographics of Thunder Bay and Indigenous youth who come to the city for their studies. It states:

“When those residing in the boarding homes fail to show up at 11 p.m. [curfew] exactly, it sometimes happens that the boarding home will call in a missing person but with no identifying information or the reason for the call. With the new policy, categories have been created to ensure the appropriate steps are taken and the appropriate information is received.”

The new policy classifies “at risk” individuals and requires a classification of search urgency.

“The implementation of the new policy demonstrates the awareness and responsiveness of Thunder Bay Police Service.”

## Media Release Policy Review

TBPS submitted that its Media Release Policy was reviewed and extensively updated in July 2017. The revised policy calls for more oversight in making and publishing any media releases in relation to major cases, to ensure that there will no longer be premature declarations of non-criminality or criminality. TBPS also stated the service “recognizes the need to ensure family members are kept in the loop” during investigations and will provide updates to families “to the best of the service’s ability without compromising ongoing investigations.”

The service created a new civilian social media coordinator position. That person’s duties include being responsible for the TBPS website and social media presence as well as assistance with media relations and strategic communications planning. TBPS submitted that it has seen a “huge growth in its social media presence” since the position was filled. The service also stated that overall negative media reports have decreased significantly and transparency has increased. For example, TBPS is now posting Police Service Act disciplinary hearing schedules on its website.

## Local Bail Committee

TBPS sits on the Local Bail Committee, where its representative has raised the issue of bail violations in relation to alcohol. The service presented statistics to the committee demonstrating that between January and September 2016, over 1,000 of 3,913 bail breaches that occurred were as a result of an alcohol or drug-related breach. TBPS submitted that it is hopeful that other justice system participants will curtail these conditions so an alternative to jail can be found.

“The police service is sensitive to the issues that affect the Indigenous Community in Thunder Bay and, thus, attempts to seek out better ways to address these issues than through arrests.”

In November 2017, the Crown Attorney’s Office issued a new policy manual that addressed bail and training of Crowns and officers that requires a balancing of the rights of the accused and the interest of public safety.



# TBPS Organizational Change Initiatives

## Diversity Project

The Diversity in Policing Project and Beyond was launched in 2004. Phase 1 focused on research and development, establishing a project management team, and establishing a validation group. Phase 2 was to focus on reviews of internal policy, procedures and employment systems. Phase 3 was to focus on delivering training, implementing policy changes and sharing the project. TBPS submitted that UNESCO recognized the Diversity Project as a project “noteworthy for fighting discrimination and racism.”

The Phase 1 report found participants in the focus groups recalled emotionally charged memories from years ago as if they occurred yesterday. The report reflected that these negative experiences may prove difficult for TBPS to overcome. Participants wanted TBPS to stop race-based targeting and profiling. They wanted TBPS to keep building relationships with Aboriginal/racialized communities and participate in culturally sensitive/anti-racism training.

In terms of employment and human resources, the report found that TBPS had done much work on its systems and achieved success, while needing work on creating a more welcoming environment for Aboriginal and other visible minority members.

On police/community relations, the report found TBPS had built in accountability mechanisms through the creation of advisory groups and committees such as the Aboriginal Liaison Committee, the Validation Group and Project Management Team.

No Phase 2 report was completed.

## Organizational Change Project

TBPS submitted that it began an Organizational Change Project in February 2017, with the help of Dr. Leisa Desmoulins, the author of the 2007 Diversity in Policing Phase 1 Report. The Organizational Change Project includes four areas of change: Aboriginal Liaison Unit, Recruitment, Communication and Training. The project was approved by the TBPSB in October 2017.

In December 2017, TBPS asked its members to fill out an internal survey to provide a base line for the project as to the composition and make up of TBPS. In January 2018, the service advertised for members to join the working group to assist in implementing organizational changes. The committee is comprised of three community members and four service members.

The first meeting was held in April 2018. At that time the committee was introduced to “the current landscape” of the service, provided an explanation of the previous diversity project and provided information regarding the trip TBPS executive took to Saskatoon, Regina and Prince Albert. At the second meeting in May 2018, the Aboriginal Liaison Unit presented on what the job of the unit entailed. Regular meetings are planned.

# Relationship Building in the Community

The TBPS submission highlighted the large number of community initiatives and projects it has been engaged in over the years. It observed that the Aboriginal Liaison Unit, which has been active since 1995, was set up to establish and maintain positive relationships with Indigenous communities. The School Resource Officers (SRO) provide a school presence to promote mutual trust and respect between students and police. Aboriginal Liaison Unit officers have flown to northern communities to provide student orientations. The ALU and SRO have also been involved in a summer camp in Thunder Bay.

The Community Services Branch (which encompasses ALU, SRO, Community Response Team, Traffic, and Beat Patrol officers) have been involved in many community initiatives including NAN/SOS Shelter House BBQ Fundraiser, regular visits to DFC, NAN Golf Tournament, Kingfisher Cultural Camp, Matawa Learning Centre Graduation, Fort William First Nation Youth Job Fair and Seven Generations Policing and Justice Services Symposium.<sup>174</sup> TBPS submitted that:

“Acting Police Chief Hauth has been working on strengthening the relationship with various Indigenous communities. For example, she has reached out to NAN and Fort William First Nation and has begun to form a relationship of trust. She has also reached out and met with the Treaty Three Chief of Police and is in the process of organizing a community visit with the Chief of Rainy River First Nations and the Grand Chief of Treaty 3.”

TBPS also submitted that it is running a poster contest with Fort William First Nation to allow emerging local Indigenous artists to display their art at the police station. It will also display a copy of the Robinson-Superior Treaty in the police station to acknowledge the territory.



TBPS submitted that some of the other major community initiatives that it is involved with include:

- 211 Reporting working group for racism incident reporting
- Graffiti Guard Program
- NorthBEAT Collaborative, working to address Barriers to Early Assessment and Treatment in Northwestern Ontario
- Thunder Bay Hate Crimes Awareness Committee
- Community Child and Youth Mental Health Planning Table on rapid community response and mobilization to address urgent mental health situations for youth
- Drug Awareness Committee
- Alcohol Working Group
- Safe Arrival Program
- Crossover Youth Steering Committee – connection between youth in care and involvement in the criminal justice system
- Zone Watch 2016 Initiative of pedestrian safety and winter jacket drive
- A situational table project in conjunction with the regional Human Services and Justice Coordinating Committee (HSJCC) to look at the implementation of a “hub” model to provide immediate coordinated case management services to at-risk clientele

The TBPS submission cited a 2015 City of Thunder Bay Citizen Satisfaction Survey that reported that nearly 90 percent of people surveyed by telephone were satisfied with the police service, two out of 10 residents “strongly agreed” that the city was relatively safe and eight in 10 believed that racism and discrimination were serious issues in the city.

## **Coroner’s Inquest into the Deaths of Seven First Nations Youths**

In June 2016, the Coroner’s Inquest into the Deaths of Seven First Nations Youths was concluded in Thunder Bay. TBPS submitted that:

“The recent joint inquest into the death of seven Aboriginal youths should be used to guide the findings of the systemic review ... There were no findings or recommendations directed at the police service with respect to the investigative process, nor was there any evidence found that would lead to the conclusion that further investigation was required. In fact, what should come as a result of the inquest findings and recommendations, is that Thunder Bay Police Service conducted thorough investigations into the deaths examined at the inquest. The inquest and the parties involved, examined in minute detail the policies and practices of Thunder Bay Police Service in death and missing persons investigations and did not produce any recommendations directly related to the investigations themselves.”

Eight of the 145 recommendations from the verdict of the coroner's jury were directed at TBPS. In 2017, TBPS received a grade of B+ from Aboriginal Legal Services (counsel to six of the seven families of the youths from the joint inquest) for its implementation of the coroner recommendations at the one-year mark. The overall grade for all of the organizations named was C+. <sup>175</sup>

TBPS submitted the following responses to the inquest jury recommendations:

### **In response to jury recommendation 48 – expanding the school visit program**

This recommendation called on TBPS and NAPS to continue to pursue and expand the joint "Grade 8 Visit Program." TBPS is working with NAPS and Wasaya Airlines to facilitate visits by TBPS officers to students and their families in remote communities who will be travelling to Thunder Bay to attend school. NAPS has agreed to lend TBPS its court plane to allow for these visits. TBPS is in discussions with various First Nations educational facilities to begin a joint project that will have TBPS officers attend with education facility staff to participate in orientation sessions with students in their home communities. The service is also in discussions with NAPS to prepare joint presentations with its community officers. TBPS said it is dedicated to finding additional ways to bridge the gap between Northern First Nation communities and Thunder Bay.

### **In response to jury recommendation 91 – timely reporting of missing students**

This recommendation addressed actions to be taken to ensure the timely reporting of missing students and consistent practice among institutions when students are reported missing or during a sudden death investigation. TBPS is working with the educational facilities on a missing persons' protocol and a set list of descriptors along with contact information for on-call workers at the educational facilities.

A working group was formed and TBPS supplied its Missing Persons Policy to the group, as well as consent forms for the release of student information in case a student goes missing. Student lists and on-call worker lists are being provided to TBPS. The working group is creating an "On-Call Communication Centre," which would allow all Indigenous educational facilities to access one centralized telephone number to report on the status of a missing student. This system would not replace the police reporting process for missing persons. The working group has finished creating an information form with descriptors/identifiers, which is being reviewed by the educational facilities. The Missing Persons Policy was reviewed and training was provided to officers on the new policy and procedures. TBPS has planned a public awareness campaign around the issue of missing persons.

## **In response to jury recommendation 94 – joint protocol on best search practices**

This recommendation called on TBPS and NAN to create a joint protocol on best search practices to be translated into Cree, Ojibway and Oji-Cree for distribution to community search teams. TBPS is working on the “Bear Clan” initiative with the Deputy Grand Chief of NAN. The Bear Clan is a community-led initiative led by women who patrol the streets and interact with community members with friendly greetings, food, clothing and water. The Bear Clan will also support missing persons searches.

TBPS has trained members of the Bear Clan in Thunder Bay for personal safety. TBPS is working with NAN to organize joint patrols between TBPS and the Bear Clan. TBPS has also obtained memoranda of understanding from 13 police services regarding Missing Persons and Volunteer Searchers to assist in the creation of a joint protocol.

## **In response to jury recommendation 96 and 97 – purchasing alcohol for underage individuals**

These recommendations addressed the issue of individuals purchasing alcohol for underage individuals. TBPS and LCBO created a task force to develop policy and guidelines to assist LCBO in this area. TBPS recommended that LCBO institute a trespass policy for identified “runners.” TBPS provided a list of “triggers” to the LCBO to assist with determining who could be a “runner,” and is working with the LCBO to draft a protocol for reporting “runners” to the police. The

Runner Project Plan continues and will be revised and revamped to ensure that second party purchasers and those selling alcohol illegally are caught. TBPS and LCBO are also discussing possible public awareness campaigns. The LCBO has placed posters warning the public of the legal consequences of selling alcohol to minors and will launch an online video on this issue.

## **In response to jury recommendation 115 – safety audit for Thunder Bay river areas**

This recommendation addressed collaboration on terms of reference for a safety audit of river areas frequented by First Nation students and youth. TBPS undertook a two-part initiative. TBPS conducted an audit of incidents involving intoxicated persons along the river areas, and then met with representatives from Shelter Houses’ S.O.S. program (Street Outreach Services), Dennis Franklin Cromarty High School and Northern Nishnawbe Education Council for input to determine places most frequented. Increased uniform patrols were also instituted and, if intoxicated persons were found, officers called S.O.S., or escorted them home, to the hospital or to a safe area. If a student was identified, the appropriate educational facility was contacted. Data is being tracked from these incidents. A safety audit was also conducted by a Safety and Security Specialist from Windsor Police. The report and recommendations were submitted and TBPS is acting on them.

In November 2016, TBPS’s Uniform Branch implemented a Riverway/Floodway Monitoring Project that involved identifying high risk areas and requiring officers to

conduct three foot patrols of the high risk areas each day. If intoxicated persons are found, appropriate action to be taken would consist of: escorting the individual home or to a safe location (Shelter House or detox); confiscating the alcohol; and, as a last resort, apprehension if necessary to ensure the safety of the individual. Statistics regarding interactions are being kept.

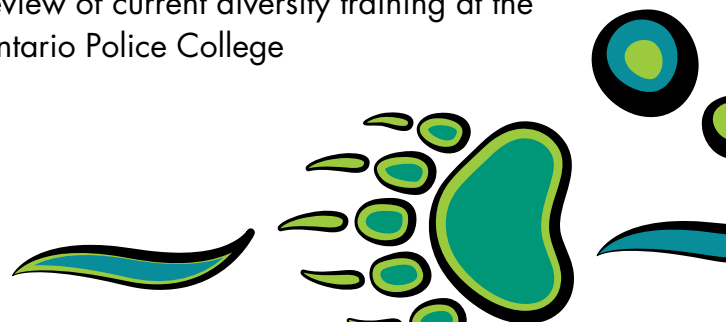
An information pamphlet was also produced and distributed to residents and business owners along the river ways.

## **TBPS Recommendations Regarding its Policies, Procedures and Practices**

TBPS submitted the following recommendations to the systemic review that the service believes would assist in making policing policies, procedures, and practices discrimination-free:

- Renewed, and continued policy review on existing cyclical rotations
- Updated training initiatives with a focus on diversity and direct and indirect racism issues and biases
  - Specifically, for Thunder Bay, focus on partnership with NAPS in the areas of training, community visits and joint projects

- Strategic utilization of internal units
  - Specifically, for the Thunder Bay Police this could mean reviewing the role of the Aboriginal Liaison Unit with a look at attaching portfolios to each officer within the unit, and incorporating recruitment, hiring and outreach strategies into the roles
- Province wide Diversity Project Model
- Community involvement and media, and social media, presence to ensure the community is aware of service's initiatives and service's commitment to discrimination free policing
- Creation of clear and concise terms of reference for newly formed, and existing, committees
- Establish an Indigenous community outreach strategy for the service
  - Specifically for Thunder Bay, creation of protocols and written policies for the service's recruitment strategy
- Continue to build and strengthen partnerships with prominent Indigenous organizations
- Continuous movement to a culturally sensitive police service model through continued education and open forum discussions
- Ensure media releases are handled as per provincial Major Case Management guidelines
- Review of current diversity training at the Ontario Police College





# Comments from Interviews with TBPS Officers

Many TBPS officers interviewed for this review talked about workload and resourcing issues. Some expressed the need for more Indigenous officers and officers from racialized minorities. There were ideas about why more Indigenous officers were not applying for positions with TBPS, ranging from barriers around the formal documents required for background checks, to how recruitment and engagement with Indigenous communities occurs. Officers identified cultural training and more education about Indigenous communities as training they would welcome. Officers also talked about police relations with members of Indigenous communities. Some of their comments are reproduced here:

## Challenges in Policing

“So, as far as resources, we can’t keep up. It’s impossible. One of the things the Chief Coroner said is, “How can we help you?” I said, “Give us more manpower.” See, it’s with everything that’s going on right now in Thunder Bay with the Indigenous community – federal government piping in that things need to change – it’s a perfect time to get funding for additional officers here. I said, “We could use five more officers just in CIB.”

“There’s not enough [officers] on the road, there’s not enough in our unit... there’s not enough anywhere and where do you draw from? If we [in a particular unit] get more, you’re taking from somewhere else.”

“Manpower is a big thing. There’s not a lot of guys and we’re busy and sometimes you run ragged. It’s absolutely a stressor for us. The call volume is usually fairly steady or it’s high and there’s not a lot of people working. It makes it hard on guys.”

“The first thing that comes to mind is the school guys and the ALU guys work on a Monday to Friday schedule. And if we’re dealing with these people at night, we’re not calling them [ALU officers] at night to deal with things. We just don’t unless it’s some special circumstance.”

“Manpower is insane. The fact that this city gets sometimes policed by, I don’t know, seven, eight uniform officers at a given moment is absolutely irresponsible.”

## Relationship Building in the Community

“When we started this community policing, the Zone policing, there was ideas that we were going to be working dedicated zones. That it was for us to get into the community. To know the community members. That we could kind of start to build trust in those communities and have community consultations and come up with ideas that are affecting those areas, and work with those areas. And it never really came. For me, I never saw that happen. Just because we were so busy on the road and so understaffed.”



"I think we've built a lot of great relationships with the organisations. If you go around and talk to some different groups in town I think they'll tell you that. Sometimes it's frustrating because sometimes all the great work that we do doesn't get recognised. Our social media guys here, communications people, try to do a lot of positive stuff and put it out there. "Hey, this is what we're doing," and that. But, you know, one dumb thing happens and it kind of sets us completely backwards. So, sometimes it's frustrating. I mean, all the work and all the great relations we're building and it just seems to kind of get pushed backwards."

"I do "wash court" on weekends. After court we transport to the [district jail]. This is my time to engage, I want to keep people as happy as possible. I've got to take them to the farm or to the DJ or to whatever, I want to have a good conversation with these guys so they're not really pissed. So this kid, 16 or 17 years old, says he just came to Thunder Bay. While he was still on the reserve, he said he was told, "Don't trust police in Thunder Bay. They kill Natives." "And you believe them?" He said, "What am I supposed to do? Of course I believe them. They're telling me, when you go there, don't trust a cop." Okay, well, that doesn't happen. So, I'm thinking, "It's not the first time I've heard something like that." Before they even come to Thunder Bay, some of the kids, they're being told that we're bad. They're being told stories. How do we combat that? I don't know. I don't know the answer. How do I fight that?"

"You need to start building rapport early. And, I think that's our big problem here is – the unfortunate part is – we're dealing with everybody at a time where it's already in crisis. It's unfortunate. If there was, if there was some way to slowly integrate that relationship or at an earlier stage, then that would be much better."

"Policies are great for when you need to establish rules, but I don't know that policy is required as a person just trying to get out in the community and be viewed upon as being real people and trying to build bridges."

"So, like, if there's a pow-wow send some people. If it's a day-long event, send a couple of guys in there. Let them walk around. I've been to four pow-wows. I've been to several walks. They [other officers] have been to none. Maybe if they went to them they would develop relationships. That's something that we do on our part. The chief of police has sole discretion on use of manpower. So, how we accomplish that, I don't know."

## Media

TBPS submissions and individual officers interviewed expressed the concern that the media and social media exacerbate any divide between Indigenous communities and the service. In its February 2017 submission to the OIPRD, TBPS stated:

"Unfortunately, the perception sometimes portrayed by the media and certain leaders in Thunder Bay is one of a divide between the Indigenous community and the service; this acts to cast doubt on the

truth that the police service is striving to be a better leader and advocate for Indigenous persons. Part of the challenge faced by the police service is in getting out from behind this shadow of doubt and continuing to move forward and improve upon the solid foundation that currently exists. The police service acknowledges that the perception of the service and its members has become the reality for many Indigenous citizens and that changing the perception is just as, if not more, important as implementing new policies and procedures.”

In interviews conducted for this review, officers expressed similar views:

“...for the most part I think that relations are good. I think that they’re strained mainly by some individuals in the Indigenous community who have all the clout, all the say and they have the media’s ear. That’s my personal belief from what I’ve seen.”

TBPS also submitted:

“One of the biggest challenges facing the service is how the public perception of racism and discrimination in Thunder Bay gets transferred onto the police service. The media, as well as social media, tend to over-report allegations of racial incidents involving the police, and under-report the good faith efforts of the service to build and improve its relationship with the Indigenous community.”

We heard from officers who attributed much of the division between TBPS and Indigenous communities to negative stories in the media and social media:

“I see the same distrust being a cop and talking to Aboriginal people. They don’t trust us. Whatever that’s from. Whether it’s from past experiences. I think a lot of it has to do with what people hear in the media, social media. What they hear on the street. And, a lot of it’s not true. A lot of misinformation gets passed around and then it carries a heavy weight.”

In a follow-up submission, TBPS stated that, since it hired a social media coordinator and increased its social media output, the overall negative media reports decreased significantly and that it has made considerable efforts and progress in changing the way in which it is portrayed.

The best antidote to TBPS’s concerns about how it is portrayed in the media is ultimately real organizational and institutional change and robust efforts by TBPS to publicize, through its own efforts, including social media, what it is doing. I do acknowledge that TBPS has increased transparency with its expanded use of social media and is posting more information to its website, including Police Service Act disciplinary hearing proceedings.

Any extended discussion about the role of the media or social media is beyond the scope of this review. Of course, it is important for TBPS to inform the media on what it is and is not doing. However, we also heard efforts on the part of some officers to blame the media and Indigenous leadership for its poor relationship with Indigenous communities, without introspection about TBPS’s own contribution to that poor relationship. This is also unhelpful.

# OIPRD Comment on Ongoing TBPS Initiatives

During my review, we met with TBPS's senior management on a number of occasions. When doing so, we identified a number of systemic issues which, in my view, could not await completion and release of my report. TBPS advised us of initiatives it had undertaken prior to our review, and more importantly, new initiatives during my review. TBPS's submissions have been summarized in Chapter 6 of this report.

**I acknowledge that TBPS has taken steps both before and during the systemic review to address concerns raised about its relationship with the Indigenous communities. I think it is important, especially in the context of a report which at times sharply critiques the work of TBPS to also acknowledge and support positive initiatives which, in my view, may enhance the quality of policing in Thunder Bay and the relationship of the service to Indigenous people, especially when coupled with the recommendations made in this report.**

I acknowledge and support the creation of a Sudden Death Review Committee. This a much-needed measure given the investigative deficiencies and lack of supervisory oversight that we identified during my review. I am advised that the committee has begun showing its effectiveness in providing oversight, and drawing investigators' attention to additional measures needed to ensure complete investigations. I am hopeful that this committee, together with the recommendations I have made in this report, if implemented, will significantly improve the quality of investigations into Indigenous missing persons and sudden deaths.

TBPS took positive and concrete steps in responding to the Coroner's Recommendations from the Coroner's Inquest into the Deaths of Seven First Nations Youths. The work of implementing these recommendations is still ongoing. I do however, disagree with TBPS's conclusion that the coroner's inquest supports the view that TBPS's investigations into Indigenous sudden deaths were thorough and beyond serious criticism. The inquest did not engage in the detailed review of those investigations that we undertook. My review revealed serious deficiencies in four such investigations.

An important aspect of repairing the relationship between TBPS and Indigenous communities will be some acknowledgement of these deficiencies publicly, as well as a commitment from TBPS's leadership to do much better.



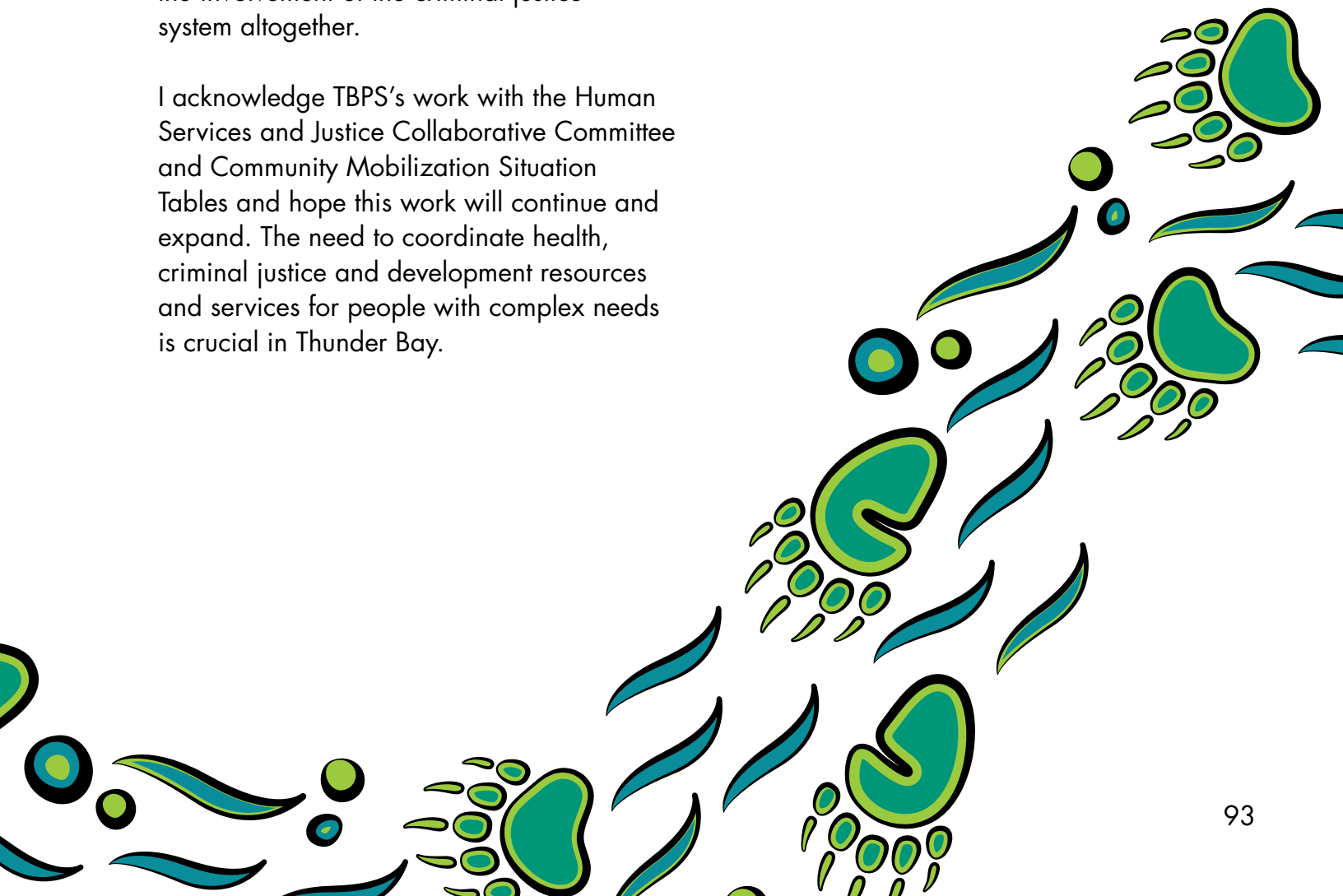
I support TBPS's approach to media releases through its new Media Release Policy. The need for TBPS to modify its policy on media releases was obvious based on the ill-advised releases identified during both the coroner's inquest and my conduct investigation pertaining to the Stacy DeBungee case.

I support a greater emphasis on non-criminal approaches to substance abuse. TBPS's work, through the Local Bail Review Committee, to have conditions involving abstinence from drugs or alcohol reviewed. It is well documented that such conditions may exacerbate the plight of vulnerable members of the community, inducing breaches of bail and resulting in arrests. Officers justifiably identified the absence of such resources as a significant impediment to diverting matters out of the criminal justice system or avoiding the involvement of the criminal justice system altogether.

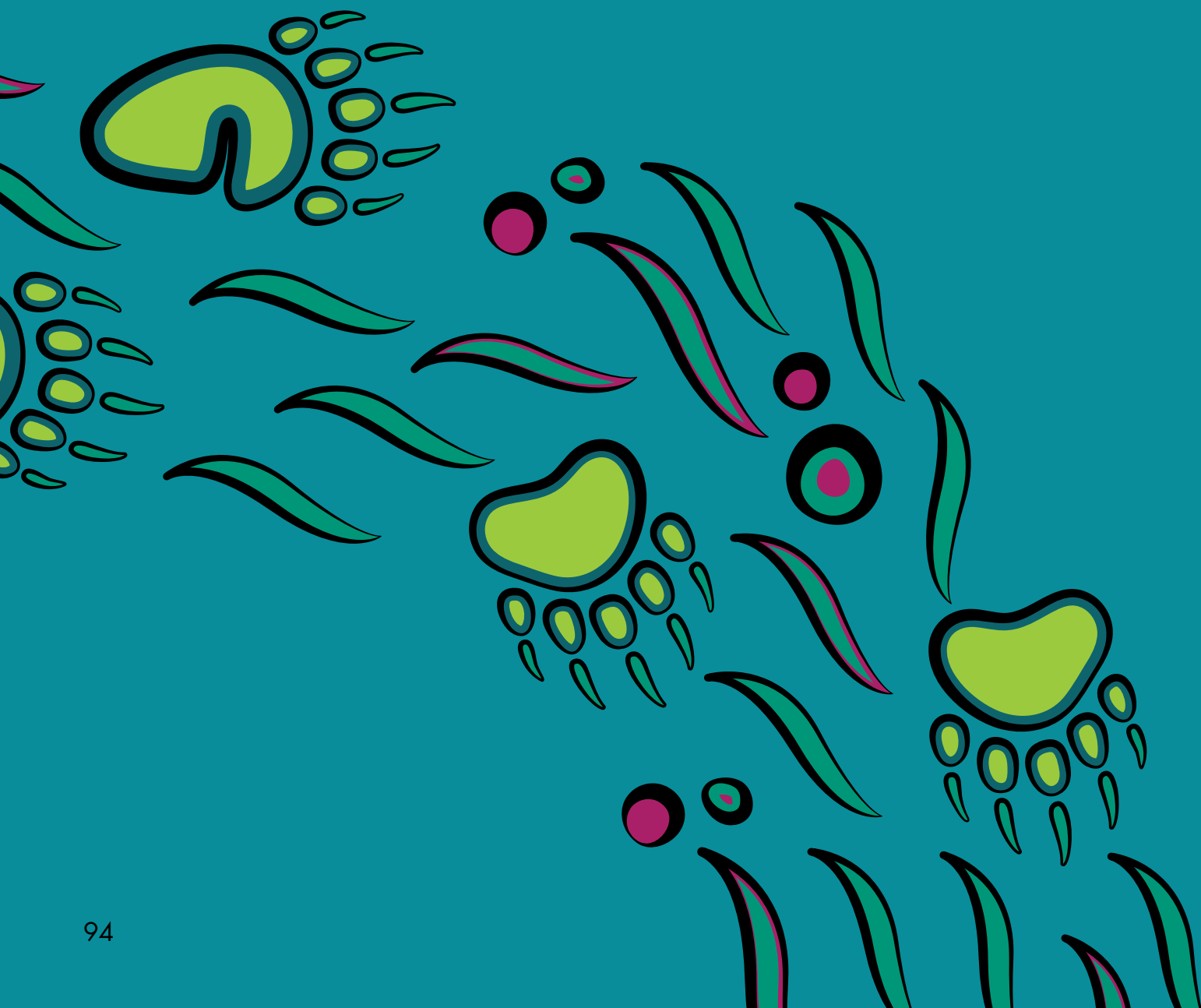
I acknowledge TBPS's work with the Human Services and Justice Collaborative Committee and Community Mobilization Situation Tables and hope this work will continue and expand. The need to coordinate health, criminal justice and development resources and services for people with complex needs is crucial in Thunder Bay.

I encourage TBPS to push forward with its work on a Joint Mobile Crisis Response Initiative. I am aware that the initiative is contingent on funding; however, having police officers and mental health crisis response workers team up to respond to mental health crisis calls is a service that is much needed in Thunder Bay.

I support TBPS in implementing its organizational change project, "Shaping our Future." Its goal, "to re-right relations inside and outside TBPS (particularly Indigenous groups) to respond to call of systemic discrimination within TBPS," is laudable. Success can only be measured once the extent of organizational change is known. I am hopeful that this project will integrate the recommendations made in my report to ensure real change.



# CHAPTER 7: OIPRD CASE REVIEWS



Some of the OIPRD's most important work during this review involved an independent examination of specific investigative files pertaining to Indigenous people. This allowed us to identify systemic failings. Our primary focus was on the investigations of Indigenous deaths, particularly sudden deaths. However, we also examined several non-Indigenous death investigations, as well as one investigation of a matter that did not involve a death.

In total, we reviewed 37 individual cases handled by the Thunder Bay Police Service. Our case reviews involved a detailed examination of the TBPS investigative file as well as related documents. TBPS cooperated in providing requested documents. Our review also exposed significant deficiencies in what TBPS records or maintains in its investigative files. A paper review depends on the completeness of the documents available to us.

The OIPRD investigators, including a former senior homicide and major crime investigator, also conducted interviews of officers involved in a number of the cases we examined. In some instances, officers provided information not available in the police investigative file. Officers frequently identified what they perceived as systemic deficiencies that should be addressed. We also interviewed a significant number of police and civilian employees of TBPS on the issues facing the police service more generally.

In some instances, we were dealing with cases before the courts. Our reviews were limited for those cases in order to not prejudice ongoing proceedings. We also conducted a paper review of some of the

identified Missing and Murdered Indigenous Women and Girls cases, recognizing that some of the older files had limited documents available. We recognized that the ongoing National Inquiry into MMIWG undoubtedly overlaps with my review.

While the systemic review was ongoing, the OIPRD also investigated several conduct complaints against TBPS officers. I have taken into consideration what I learned during those conduct investigations, while ensuring the information collected by the systemic review would not be used to advance the conduct investigations. Given the nature of a systemic review, we made it clear to any officers interviewed for the systemic review that the contents of their interviews could not be used as evidence in a conduct investigation undertaken by the OIPRD now or in the future. Recognizing that the DeBungee-related disciplinary proceedings remain outstanding, we have been careful not to provide detailed information in this report about what witnesses said to us during the conduct investigation.

**I am recommending that nine of the cases we reviewed be reinvestigated. I also recommend a mechanism to address additional cases that might need to be reinvestigated.**

This report is designed to respect privacy issues surrounding individual cases, to the extent possible. This is done, in part, to preserve the integrity of potential future investigations or proceedings relating to these cases, and in part, to respect those directly impacted by those cases. In particular, the names of witnesses and officers are not disclosed in this report,

though some of those names may already be in the public domain. This approach is consistent with the systemic nature of the OIPRD's investigation and report.

I am recommending that nine of the cases we reviewed be reinvestigated. I also recommend a mechanism to address additional cases that might need to be reinvestigated.

## Case Review – A.B.

A.B. was a 28-year-old Indigenous woman. She was found near death on top of a small embankment at the south end of the McIntyre River railroad bridge at about 8 a.m. on March 29, 2016. She was lying partially on a winter jacket on the gravel and snow. She was wearing a T-shirt and pajama-type pants which had been pulled part-way down her buttocks. The clothing she had on was wet and frozen. The ground beneath her was also wet. She was wearing socks, although one boot was next to her and the other was found some distance away along with a toque. Clothing and belongings were scattered about the scene.

Paramedics transported her to hospital, where resuscitation attempts were made; however, she died shortly thereafter. Police officers worked to determine her identity, as no identification documents were located where she was found. She was subsequently identified as A.B.

One of the officers who first responded reported that he had not observed any signs of physical trauma, scrapes, cuts or bruises. Emergency staff at the hospital indicated that

the deceased had scrapes and bruising on the shin and knee areas. Many injuries were later documented at the autopsy. The cause of death was listed in the coroner's report as hypothermia, and the police reports and case file supplied to the OIPRD listed it as a sudden death – accidental.

A support worker at Shelter House's managed alcohol program facility, Kwae Kii Win Centre, where Ms. A.B. had been living for about one week, last saw her at about 9:30 p.m. on March 28, 2016. Ms. A.B. left in the company of another resident (B). B returned to Shelter House the following morning. He was intoxicated. The support worker had information that Ms. A.B. and B had also been accompanied by another male (C). B and C left Shelter House that morning before the police arrived.

Police located and informed Ms. A.B.'s next-of-kin of her death. A media release was issued that evening.

On March 30, 2016, upon seeing the front page of the morning newspaper, B asked staff at Kwae Kii Win Centre if the article



was about Ms. A.B. He appeared to be upset and began to hyperventilate. That same afternoon, police located B at Kwae Kii Win Centre. He advised the officers that he was likely the last person to see Ms. A.B. alive. He provided the following information to the police, who did not caution him:

“He and Ms. A.B. went to the Superstore to go to the wine store but it was closed. He bought some mouthwash and A.B. stole some. They “walked down the back road through the trail.....they walked towards where the tracks were and sat down. They had consensual sex and police would find his semen in A.B.”

He advised that they sat in the area for a bit. He then got up and was going back to Shelter House as he had a probation appointment in the morning. Ms. A.B. chose to remain. When he left, there were people coming toward Ms. A.B.

He stated that he knew the police would want to speak to him and wanted to help. He said he freaked out when he saw the newspaper with a picture of where they were sitting. He agreed to show officers where they had been, and to provide a videotaped statement.

Later that same day, B was interviewed on videotape. The first 19 minutes of the video relate to police efforts to obtain a consent DNA sample from B. The investigator read the preamble for obtaining a consent DNA sample, inserting that the police were “investigating the allegation of a sudden death.” (We note that in law, there is no such allegation as “sudden death,” as opposed to an allegation of a criminal offence relating to death.) In the circumstances, the preamble was largely meaningless.

The DNA sample and video statement were taken more than 24 hours after Ms. A.B. died. Clearly officers did no research on B, otherwise they would have discovered that B was on the offender DNA database. That would have indicated to them that a DNA sample was unnecessary and that B had been convicted of a crime that required and ordered a DNA sample for the database.

B’s statement was taken as a witness statement (without any caution), although he was offered a lawyer as part of the consent DNA process, which he declined. It was unclear what the precise purpose of the interview was. B appeared to be under the impression that, as he and Ms. A.B. had had sex, he was “clearing his name” by providing a DNA sample.

In his interview, B essentially repeated what he had told police earlier in the day. However, he added some additional details. Unprompted, he stated that he did not have any arguments with Ms. A.B.

On March 30, 2016, the autopsy was held in Toronto. The autopsy report reflected the “the victim was found unconscious outside in an ambient temperature of -7 C. She was transported to hospital where she suffered a cardiac arrest. Her body temperature was recorded as 21.6 C. Resuscitation efforts continued while she was being warmed but she remained pulseless and was pronounced after two and a half hours. **There were police concerns regarding possible sexual assault, due to the partial undressing of the decedent at the scene.**” (Emphasis Added)

The pathologist noted multiple signs of recent injury to the head and neck, upper limbs, torso and lower limbs. These injuries did not contribute to her death. Ms. A.B.'s blood alcohol level was 282 mg/100 mL. Hypothermia was identified as the cause of death. The pathologist also observed that Ms. A.B. may have removed her clothes on her own. A TBPS occurrence report, referencing the coroner's report, stated that "at this time no foul play found to be involved in this investigation."

The Centre for Forensic Sciences (CFS) report reflected that blood conforming to Ms. A.B.'s DNA profile was found through fingernail clippings taken of her left hand. Fingernail clippings from the right hand also revealed blood with two DNA profiles. Semen was detected through vaginal swabs. The DNA profile from the semen corresponded to B's DNA profile, as contained on an offender database.

There is little or no doubt that Ms. A.B. died of hypothermia. However, investigators should have focused on how she came to be unconscious, whether anyone else's actions contributed to her death – and more specifically, whether she was sexually assaulted. The pathologist recorded a police concern over whether Ms. A.B. was sexually assaulted. However, quite remarkably, no meaningful investigation took place to ascertain whether the evidence supported non-consensual sexual activity or any other criminal intervention contributing to her death. The significant fresh injuries documented, the scattering of clothing, and the evidence of sexual activity made such an investigation imperative.

It appears likely that officers treated the cause of death (hypothermia) as proof that this was an accidental sudden death. However, the police needed to do much more before they could arrive at that conclusion. Indeed, if the theory was that extreme intoxication explained why Ms. A.B.

ultimately succumbed to hypothermia, it begs the question as to how she could validly consent to sexual activity.

Unfortunately, a common theme for a number of such deaths was a failure to appreciate that hypothermia or drowning represents a cause of death, but does not answer whether others contributed to the death.

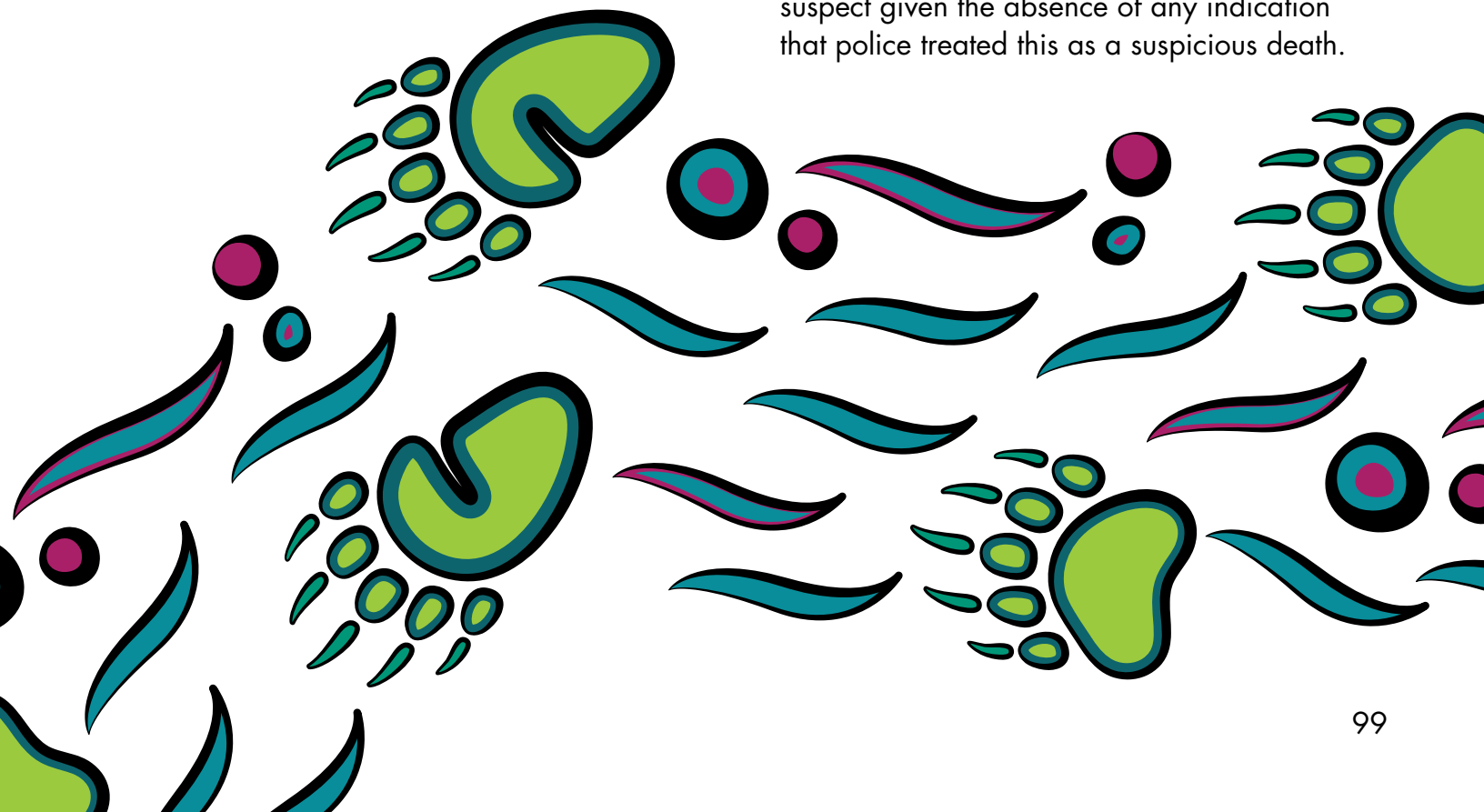
Other inadequacies presented themselves. The forensic identification officer was given limited or no direction or information about the matter. As a result, photographs and collection of exhibits were somewhat haphazard and unconnected to any dialogue with investigators. Photographs of the scene were completed before investigators even attended the scene. Subsequently, the forensic identification officer re-attended the scene to assist in a scale computerized scene reconstruction. But this could only be done by placing exhibit marker cones "in the approximate positions where the exhibits had been found earlier and seized." This



approach undermined any usefulness of the resulting computer generated scale diagram. A supervisor told us that TBPS policy was to have forensic identification officers process the scene before investigators attend. For reasons explained elsewhere, this “siloe” approach is inconsistent with best practices.

Several witnesses were never interviewed, including one of the two civilians who first observed the scene. The support worker had information that a third person had been with Ms. A.B. and B, but that person was never interviewed, and there is no indication in the file that attempts were made to do so. B provided an account that might have been corroborated or disputed, at least in part, by interviewing others he identified. Such interviews never took place.

Most troubling was the way in which B was dealt with by police. He was interviewed as a witness prior to the autopsy and prior to any true physical examination of Ms. A.B. for fresh injuries. B was under the impression that the interview was being done to “clear his name.” Frankly, the purpose of the interview and how the police regarded B are unclear from the file. B was already on the offender DNA database. Nonetheless, the police asked him for a voluntary DNA sample, with the completely ineffectual preamble that the police were investigating the offence of “sudden death,” which does not exist. Far more problematic, the interview essentially recorded what B had to say, with very few questions being asked. When B indicated, unprompted, that he did not have an argument with B, the interviewer cut him off and changed the direction of the interview. The file provides no insight as to why a video interview was requested, and again, whether police regarded B as a witness, person of interest or suspect. It is doubtful that police regarded him as a suspect given the absence of any indication that police treated this as a suspicious death.



Investigations do not meet adequacy standards simply because police have interviewed relevant individuals. At a bare minimum, police must ensure that relevant questions are asked at the interviews. It was troubling that B was never asked questions including, but not limited to, the following:

- Was C with them?
- What was Ms. A.B.'s state of dress when B left her?
- How would she have got wet?
- Did she suffer any injuries while with B?
- A detailed description of the allegedly consensual sexual activity to account for any injuries and to probe whether the activity was indeed consensual.
- What was Ms. A.B.'s state of intoxication during the sexual activity? If she was intoxicated, how was this shown? How did she provide her consent to the sexual activity?
- What was his state of intoxication during the sexual activity?
- Did he suffer any injuries during his encounter with Ms. A.B.? (Efforts could also be made to check for such injuries)
- Who, if anyone, approached as he left her?
- Why did he stop at Dease Street and Patterson Park on the way back?
- Did he speak to anyone while with Ms. A.B., or prior to being interviewed by police? What was said? What conversation took place between B and the support worker?
- Why did he raise certain issues without prompting by the police, such as the fact that they didn't argue?
- What clothing was B wearing at the time? Can police examine that clothing?

Nor was B re-interviewed once additional forensic and other evidence were obtained.

The forensic identification officer who attended the autopsy had no prior involvement in the investigation. The officer's report and notes do not reflect any steps taken on the officer's part to familiarize himself with the facts uncovered to date during the investigation. He did not speak to any of the investigators, including his fellow forensic identification officers already involved. As a result of his lack of knowledge, there is no indication that he apprised the

pathologist of relevant evidence or that he asked the pathologist questions that could inform any ongoing investigation. Neither is there any indication that the pathologist discussed the injuries suffered by Ms. A.B. If any such dialogue took place between the officer and the pathologist, there is no record of that dialogue or what, if any, details were conveyed back to the investigators.

Our examination of multiple files reflected, as a common theme, that often no dialogue took place directly or indirectly between the pathologist and investigators. Indeed,

at times, there appeared to be few or no steps taken to follow up with the pathologist after the autopsy. Several investigators told us that they have difficulty, at a systemic level, securing autopsy reports, and are not necessarily even told when they have been completed.

Ms. A.B. was only 28 years old. When she was found, she was wet, without a coat or shoes, near death from exposure, had her pants partially pulled down, and had suffered fresh head injuries as well as bruises and abrasions all over her body. There was evidence of semen in her vagina from an offender on the DNA database. She died of hypothermia shortly after she arrived at the hospital.

This was a textbook case to treat as a suspicious death unless and until a thorough investigation showed otherwise. It was also a textbook case to be investigated under the Major Case Management system. However, it was not treated as such. On the contrary, the police quickly latched onto the finding of hypothermia, disregarding the evidence that compelled further investigation. There was no meaningful investigation of B's role in the death.



The police appear to have theorized that Ms. A.B.'s level of intoxication provided a credible explanation for why she died of exposure, while never considering whether that state of intoxication was inconsistent with consensual sexual activity. At one point, a decision appeared to have been made by a supervisor that certain exhibits not be submitted for CFS analysis, pending toxicology results. It is difficult to understand why CFS analysis of those exhibits was dependent on Ms. A.B.'s level of intoxication.

There appeared to be no objective to the investigation. The file does not even make clear who was in charge. The file contains no explanation as to the basis upon which investigators concluded that no foul play or criminality was involved. The finding that Ms. A.B.'s death involved no foul play or criminal activity cannot be supported based on the inadequate investigation conducted by TBPS.

Equally problematic, the failure to truly investigate whether Ms. A.B. was the victim of a sexual assault, and the decision that certain CFS testing would be dependent on the toxicology results raise legitimate concerns that Ms. A.B.'s death was not given the attention it deserved.

One of the senior officers involved in this investigation advised us that, in hindsight, police could have done more. He did advise the coroner, before the decision was made to order an autopsy in Toronto, that the matter had to be dealt with as a suspicious death, with proper follow up. More could have been done in the interview with B and his background should have been researched. The case closed earlier than it should have

in the circumstances. The senior officer felt that excessive reliance was placed on the pathologist and indicated that he would have been interested in looking for signs of trauma and injury that would cause incapacitation or unconsciousness (not necessarily death). This senior officer was very candid about the systemic issues in death investigations (addressed in more detail elsewhere in my

report), and felt that he “treated the A.B. family well and cared about them,” but was unable to devote enough time to this investigation due to the heavy workload at the office at the time. Of course, heavy workload cannot justify inadequate death investigations. The issues around workload are further explored later in this report.

## Case Review – C.D.

C.D. was an 18 year old Indigenous woman. She had apparently been involved in a six-month common-law relationship with a male (B) who was almost 50. The couple resided in an apartment rented by C. On February 5, 2014, at 9:20 a.m., a 911 call was received from a male who identified himself as C. He reported that his girlfriend just tried to hang herself but was still breathing. Subsequent evidence revealed that C had not made the call at all.

Officers arrived at the scene after other first responders who were administering CPR. One officer spoke to a male immediately outside the apartment who identified himself verbally as B and stated that he was Ms. C.D.’s common law partner. At the officer’s request, B provided his own and Ms. C.D.’s date of birth and phone numbers, which the officer recorded in his notes. The officer read B a secondary police caution. B explained that he and Ms. C.D. had argued that morning. Ms. C.D. had threatened suicide that morning and previously. She went into the bathroom and closed the door. After a couple of minutes, B knocked on the door.

When he received no response, he split the door frame with a shovel and kicked the door in. He stated that Ms. C.D. was hanging from a pipe with a belt around her neck. He removed the belt from her neck, placed her on the floor and began CPR, rubbing her face and neck as well. He called 911. He was described as crying and shaking.

EMS removed Ms. C.D. to the ambulance to continue resuscitation efforts. B told the attending officers that he wished to go to the hospital. B was escorted into the apartment by officers purportedly to obtain some clothing. Police observed several cell phones in the apartment. B made a fuss about obtaining his cell phone which was in the bathroom. He was cautioned regarding the Criminal Code offence of obstruct police and was directed not to touch anything else in the apartment. He was allowed to leave. He told officers he had a ride waiting for him. After he departed, officers observed that he had taken the cell phone located in the living room despite the caution. The police were unable to catch up to him. He never attended the hospital. B’s name and

description were placed on the system as arrestable for obstructing police. Officers observed that the apartment was littered with drug paraphernalia and evidence of drug use and debt lists.

The coroner arrived at 11:26 a.m. and stayed for about 10 minutes. He indicated that an autopsy would be conducted. An officer reported that the coroner characterized the death as "sudden, non-suspicious." A sergeant directed that the scene be held until further notice.

Police observed that a large-diameter plumbing pipe approximately eight to nine feet above the toilet appeared to be the point where Ms. C.D. was said to have attempted to hang herself. There appeared to be disturbances in the dust on the pipe which a forensic identification officer surmised could have been made by Ms. C.D.'s hands and the belt. The pipe did not yield fingerprints for analysis. The belt was located on the living room floor. A safety razor had been tampered with in the bathroom in an apparent attempt to remove the blades. The bathroom door was damaged and splintered, and a shovel was nearby. Police also believed that impressions on the toilet lid could be those of bare feet. Impressions were developed and retained. Various items were retained and photographs of the scene were taken.

One neighbour reported to police that prior to their arrival, she heard a man and woman arguing in the apartment. It carried on from midnight until 5 a.m. She indicated that there was constant arguing coming from that apartment.

Police telephoned the apartment's renter (C) while still at the scene. He stated that Ms. C.D. and B were present when he left for work that morning. They had been living with him for approximately two months. It does not appear that he was asked any other questions. He later arrived at the apartment and refused to answer further questions put to him. He denied knowing the whereabouts of B.

Investigators attended the hospital emergency room where they viewed Ms. C.D.'s body. They observed ligature marks on her neck, petechial hemorrhaging in both eyes (which can be evidence of a choking or strangulation incident), fresh blood on her left thumb nail, numerous scars on her inside left forearm consistent with cutting, but no obvious signs of struggle. The forensic identification officer was requested to attend the hospital to document her observations.

The forensic identification officer attended the hospital. She observed that both Ms. C.D.'s right and left hand had small cuts and there was some blood on the thumbs and index fingers. Ms. C.D. was wearing a sock on her left foot, but her right foot was bare. The officer photographed Ms. C.D.'s face, hands and feet, bagged her hands and took fingerprint impressions from her right thumb and forefinger and an impression of Ms. C.D.'s bare right foot. The body bag was left unsealed since the coroner had not yet viewed the body.

The investigators were advised by the supervising officer that the scene was to be released and that the autopsy was scheduled for the next day. An investigative report dated February 5, 2014, at 9:17 p.m. reflected that "the only outstanding matter is the next of kin be notified."

On February 6, 2014, officers made contact with Ms. C.D.'s next of kin to inform them of her death.

The forensic identification officer attended the autopsy and took photographs as directed by the pathologist. The autopsy determined that the cause of death was "ligature hanging." The pathologist did not find petechial hemorrhaging. Several days later, the officer determined that the impression left on the toilet seat was a palm print, not a footprint.

Investigators attended the apartment again on February 7, 2014, in an effort to locate B. There was no answer at the door. The investigative file indicates that police called B's cell phone number (perhaps referring to the phone found in the bathroom). The file also indicates that police called Ms. C.D.'s cell phone number, to be told by a male who answered that they had the wrong number.

There is no evidence that officers took any further steps to advance the investigation based, for example, on forensic examination of the contents of the phone left behind, or based on other information about Ms. C.D.'s cell phone usage. Officers re-attended the apartment, speaking with C. C provided no further information regarding B, but provided a physical description of him and indicated that B was a street person. Investigators attended Shelter House. Staff knew Ms. C.D., but knew of no one going by the name that B provided to officers.

The investigative file indicated that a warrant would be pursued for B for obstruct police as "this investigation cannot proceed" until he is interviewed.

The investigation into the death of Ms. C.D. was deficient in several critical areas, leaving important questions unanswered which could affect the ultimate conclusions in the case.

A Caucasian male at the scene was permitted to identify himself verbally only, re-enter the apartment and take a cell phone with him, despite being purportedly escorted and contrary to clear directions from police. The cell phone may have either contained information pertaining to the death of Ms. C.D. or to potential criminal activities taking place within the apartment. The Computer Aided Dispatch (CAD) Report suggests that

this address was known to police, but there is no indication in the investigative file that this was ever researched or followed up. (We were advised that record checks had been done on Ms. C.D. which yielded negative results, but that is not documented in the file.) No formal statements were taken from anyone. No acquaintances of Ms. C.D. were interviewed to cast any light on what had transpired. First responders were not interviewed at all. Although police were in possession of a cell phone and additional cell phone information, the investigative file does not reflect any efforts to attempt to triangulate B's location or use other investigative aids which might have been available to utilize the available cell phone information.



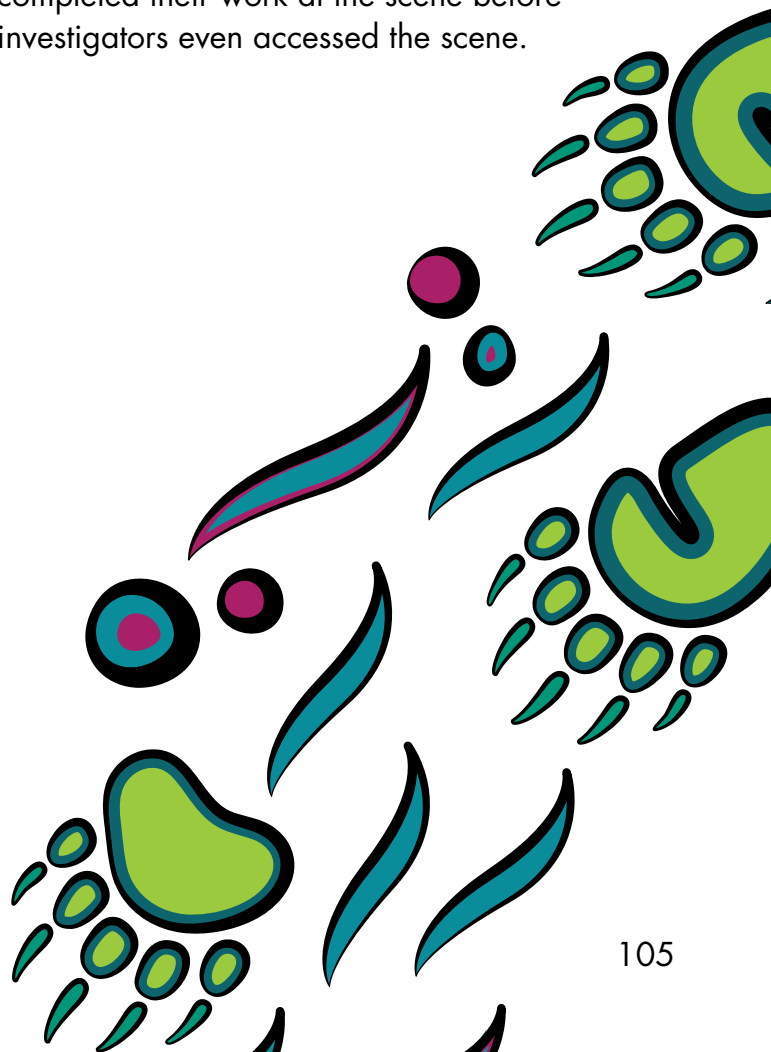
Initial observations suggested that there might be fingerprint impressions on the bathroom pipe, or a bare footprint impression on the toilet lid. Forensic work was done to follow up on these possibilities, but that work did not yield useful evidence. More importantly, there appeared to be little effort to consolidate, at any time, what police had and had not learned about the scene and what inferences might be drawn as a result.

This represents a common theme in many of the individual files we examined. There appeared to be no real structure to the investigation or consideration in an organized way of the evidence as it was collected. For example, it appears that the absence or presence of a palm print impression or a bare footprint impression did not affect the course of the investigation in any way. Nor does the investigative file reflect any consideration as to the implications of the pathologist's reported finding of "no anatomical cause of death." Did investigators expect different findings based on the theory of suicide by ligature strangulation? There is no indication that this issue was even discussed with the pathologist. The forensic identification officer said, "I would gather up my samples, sign off the paperwork, make sure I have everything and that I haven't forgotten anything in the morgue, get in my car, call CIB and say 'here's your cause of death.'"

The autopsy report reflects the opinion that Ms. C.D. died as a result of "ligature hanging." One would have expected a dialogue between the forensic identification officer and case investigators, including a discussion of the injuries and a discussion of whether the evidence was such as to rule out the involvement of others in this ligature

death. None of this took place. The coroner's investigative statement indicated that, "Her boyfriend found her and cut her down and started cardiopulmonary resuscitation and called 911." Photographic evidence of the belt did not indicate that it had been cut. This begs the question of how that statement got into the coroner's report. At very least there is a lack of communication.

Another common theme presented itself here. The forensic identification officer appeared to receive no guidance on what to seize or examine. This was an obvious deficiency in the majority of cases we reviewed. Based on our interviews, there appears to be a serious misconception on the part of some investigators that it is the sole responsibility of forensic identification officers to determine how the scene should be processed. In some cases, the forensic identification officers completed their work at the scene before investigators even accessed the scene.



In the C.D. investigation, one investigator said that it would be up to the forensic identification officer to determine whether the measurements taken at the scene were consistent with the suicide scenario. However, as reflected below, no relevant measurements were taken at the scene. Nor did there appear to be any dialogue between investigators and forensic identification officers as to whether such measurements should be taken. One forensic identification officer identified this as an ongoing systemic issue. TBPS Forensic Identification Unit officers are often not informed of key information collected by investigators. Effective investigations require that investigators and forensic identification officers work together to identify the relevant issues that affect the processing of a scene and other collection of forensic evidence.

We have identified a number of actions that we would have expected the forensic identification officers to take at the scene. These represent significant deficiencies in the investigation. We have compiled those in a confidential memo that can be made available if the case is reinvestigated or subject to internal review. These (as well as certain features of other cases summarized in this chapter) are not reproduced in this public report so as not to jeopardize any reinvestigation or internal review.

One investigator suggested to the OIPRD that a production order <sup>176</sup> to learn more about the cell phones in the apartment and their owners was not considered because the case was not regarded as a "criminal incident." Although well beyond the scope of this systemic report, we disagree with the proposition that a production order or legal alternatives to a production order were

unavailable unless police first determined that there were reasonable grounds to believe that Ms. C.D. was the victim of a crime. This is especially so since B's identity had not been ascertained and he faced a charge of obstructing police pertaining to the taking of potential evidence in the investigation. It is also relevant that there was evidence of illicit drug activities in the apartment.

The coroner briefly attended the scene. It appears that he declared the death to be non-suspicious before he had even examined the body at the hospital and before the autopsy had been performed. The scene was cleared even before the autopsy had been performed. Indeed, at least one investigator appeared to believe that there was, little, if anything, to do other than notify the next of kin, once their initial work at the scene had been completed. There appeared to be little follow-up on the part of investigators as to what, if anything, could be reasonably gleaned from the autopsy.

The file also reflects the view (somewhat contradictory) that the investigation could not proceed further until B was located and interviewed. An investigator advised us that he was quite certain that B had been eventually interviewed. We were told that he was taken into custody almost three years after Ms. C.D.'s death. However, the investigator acknowledged that he was never notified about B's arrest (yet another systemic issue we identified) and there is no evidence in the investigative file that B was ever interviewed again in connection with the investigation into Ms. C.D.'s death. A front-line officer's sudden-death report requested that the death be linked to the obstruct police charge, but again, he had no knowledge if B was interviewed when arrested.

Based on our interviews, it was obvious that there was a lack of clarity over whether this was a coroner's investigation or a criminal investigation. There was also inconsistent information as to how decisions were being made. We identified this issue in a significant number of files. It reflects basic misconceptions about the respective role of coroners and investigators.

Part of the problem rests in the related misconception as to whether a death should be characterized as "suspicious." A number of investigators only characterize a death as "suspicious" if their working theory is that criminality is likely or where there is overt evidence of foul play. This misconception also affects whether cases are investigated under the Major Case Management protocol.

The circumstances surrounding Ms. C.D.'s sudden, unnatural death should have compelled police to treat it as a potential criminal case (and in that sense, a suspicious death) pending a full investigation. In an interview regarding this case, a senior officer involved in this investigation acknowledged that this was to be treated as a suspicious death, without having to characterize it as criminal from the outset.

Here, the scene, coupled with B's explanation, may have initially presented as a suicide. However, B disappeared thereafter, having taken potential evidence with him. The 911 caller gave a false identity to the police. B was not entirely cooperative with police. B and Ms. C.D. apparently quarrelled shortly before her death. The apartment revealed evidence of illicit drug use and debt lists, the relevance of which was unexplored, as was the role, if any, of B in contributing to what transpired.

A senior officer involved in the investigation acknowledged that, in hindsight, additional forensic measures should have been employed. He also candidly described systemic issues which need be addressed, including the absence of a system in place to track autopsy or toxicology reports. On this file, the autopsy report was not contained in the investigative file, and this officer did not recall being advised that the report had been completed.

This investigation was not adequate in the circumstances. A premature conclusion was reached as to Ms. C.D.'s death and this infected the very limited work that followed. A reinvestigation is required.



## Case Review – E.F.

At 1 p.m. on April 30, 2016, police were called to a wooded area near a bike path in the area east of Hastings Place and Brant Street in Thunder Bay. A citizen walking her dog found a body (later identified as E.F.) against a fence 125 feet from the Trans Canada Highway's eastbound shoulder. The citizen also reported seeing a male party coming from the area where the body was located at around noon and provided a description of that male.

Another citizen contacted the police to report that around noon that day she and her husband had also walked their dogs in the area where the deceased was found; however, they had not observed any individuals or the body. Later, between 2 and 3 p.m., her husband observed a male crouching behind a hill looking towards the crime scene. The male was described as "Native" with black hair, wearing a brown sweater. The citizen indicated that they would be willing to speak to the police if follow-up was required.

The officer who took charge of the scene reported that death was obvious, and that the deceased was lying on her back with her legs bent to the left. He also observed that:

- Her elbows were bent with her hands palm up next to her head
- Her left hand was clutching a clump of grass
- Her right hand was holding a small branch
- Her pants were pulled down below her buttocks, but her underwear was in place
- Two hospital bands were located on her right wrist (these were from the Thunder Bay Regional Health Sciences Centre)
- There were cigarette burns on both palms

The forensic identification officer also observed EKG pads on the deceased's torso and bruising on her left arm. A uniform officer located a pink wallet near the body. Another officer located a purse on the highway side of the fence that was within the perimeter created by the police.

The coroner arrived at the scene at 2:25 p.m. He directed that the body be removed and that an autopsy be conducted in Toronto. The body was removed before some of the investigators (including the lead investigator) either attended the scene or viewed the body. The Regional Supervising Coroner subsequently advised that TBPS police officers need not attend the autopsy, and that photographs could be taken by morgue staff. According to the police, the Regional Supervising Coroner did not feel that the circumstances of the deceased's death were suspicious.

On May 2, 2016, the autopsy was conducted. Cause of death was identified as hypothermia in a woman with ketoacidosis and acute ethanol intoxication. Thirty-four external signs of recent injury to the head

and neck, torso and upper and lower extremities are described in the autopsy report. Internal signs of injury to the scalp (right and left frontal sub-scalp hematomas) were also described. There was no evidence of bony fractures.

The autopsy report listed significant findings. These included:

- Ethanol intoxication – post-mortem toxicology detected a non-fatal level of ethanol in the post-mortem blood. It can increase the risk of hypothermia
- Ketoacidosis – this may occur in diabetics and individuals who are dependent on ethanol consumption
- Hypothermia
- Injuries – there were no fatal injuries. There were multiple red contusions around the lower legs and forearms. The report stated that these could be attributed to stumbling or crawling, either as a result of intoxication or from hypothermia. There were also contusions over the anterior chest, with a fracture of the sternum. The etiology of the fracture was unclear; however, it is a common finding in individuals who had undergone resuscitation and may have occurred during a recent hospital admission. The pathologist's report did not specifically address the implications of the head injuries, though they appeared to be non-fatal.

The report was not completed until August 2, 2016, after toxicology results had been obtained. On May 2, 2016, the lead investigator was reportedly advised by the coroner that the "initial physical and internal

examinations showed no signs of trauma or violence and this death was not caused by foul play. There were bruises on the body, nothing specified for location [of the bruises]; however, nothing would indicate the death was from where the bruises had occurred."

The scene was subsequently released.

Several witnesses, other than those already referred to, also came forward. A security officer (B) contacted police to advise that on the day the deceased was found, he had a male in custody for shoplifting. The wait for police was too long so he let him go. He identified the male and stated that the male had blood on his pants.

Another witness (C) contacted police to advise that he had seen Ms. E.F. on Red River Road two days before she was found. She was with a male whom the witness identified by name (D) and two other females. He believed she was going into a store. C was contacted by an investigator. He told the investigator that he ran into D on April 31 and mentioned that Ms. E.F. had died. D looked down and said nothing. D was subsequently interviewed by officers. He contradicted C and denied any knowledge of relevant events.

On May 12, 2016, a woman (E) contacted police to advise that she did not know Ms. E.F. but had encountered her a short time before her death. Ms. E.F. was highly intoxicated and on the ground in front of a retail store. E called an ambulance that attended and took Ms. E.F. away.

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

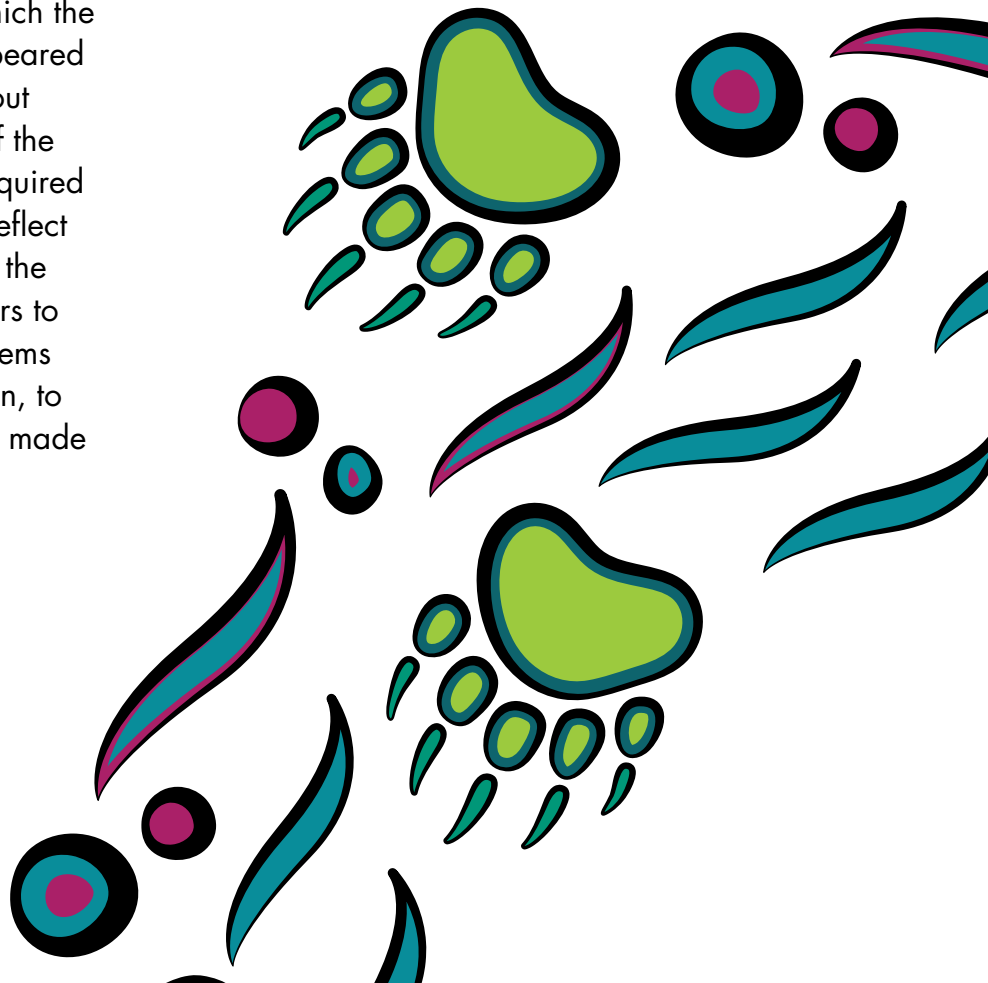
contents make oversight and accountability difficult, if not impossible. Plus, the state of these files hampers the ability of investigators to re-open cases, where appropriate, in an effective way or pursue additional leads that might become available.

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”)

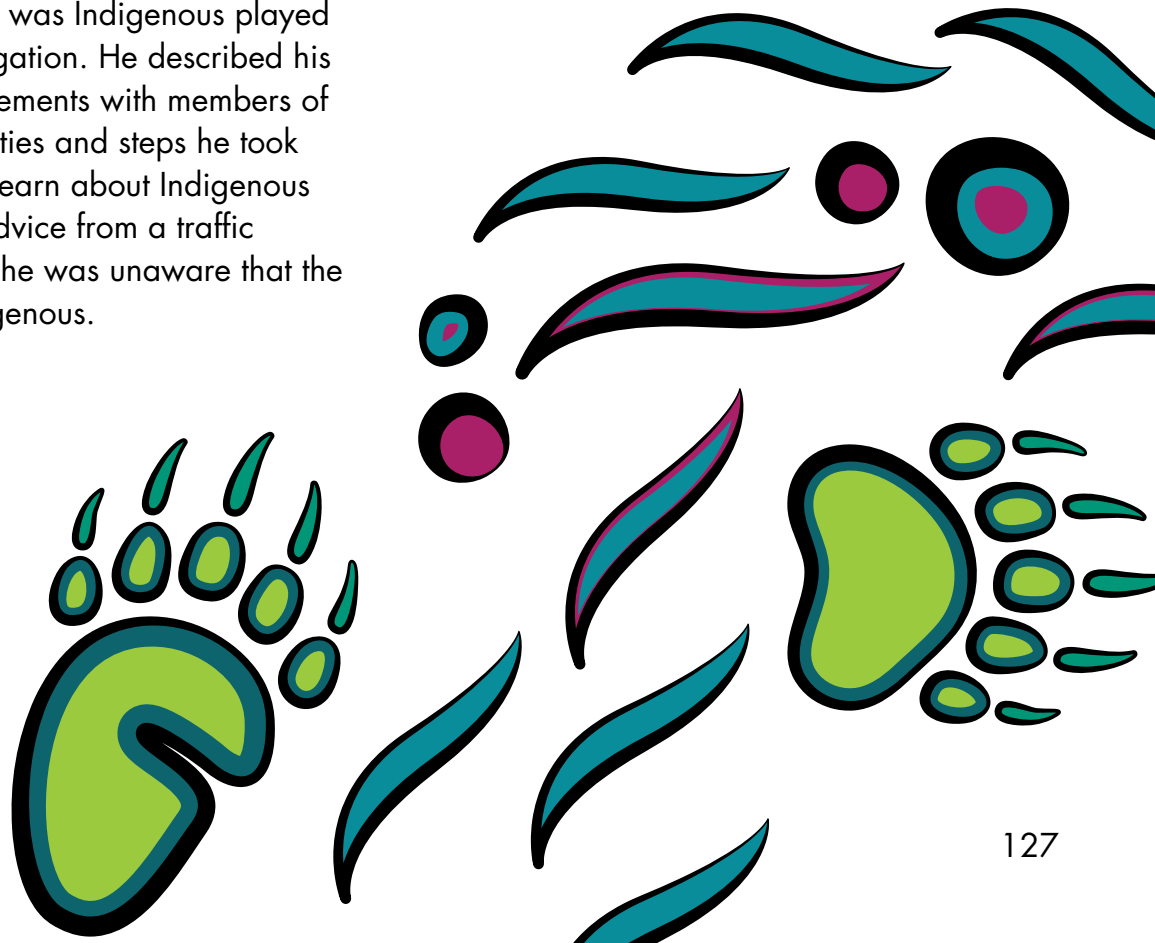
A driver has a statutory obligation to yield to a pedestrian lawfully within a crosswalk. There was no evidence that Ms. K.L. was outside the crosswalk area when she crossed the street and was struck. It was the driver's obligation to turn safely after stopping at the stop sign. The investigation failed 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.

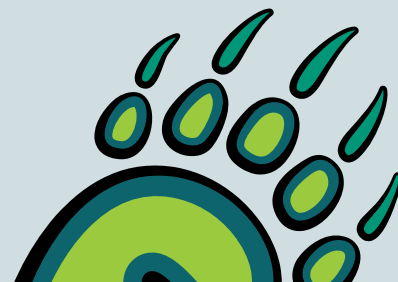
To be clear, the relevance of my findings relating to Mr. DeBungee's death to this systemic review are not dependent on whether individual officers were or were not guilty of misconduct. If the matter proceeds to a disciplinary hearing, the determination whether misconduct has been proven to the requisite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

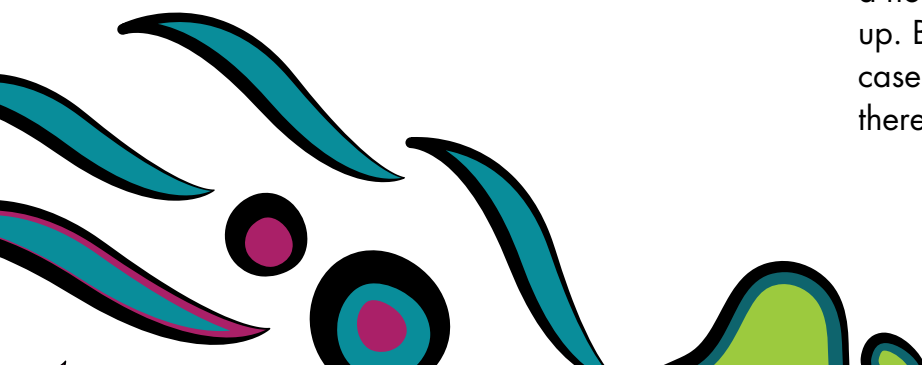
One member of the Forensic Identification Unit acknowledged that no videos were taken at the scene. She felt that the unit would only take videos at scenes they believed were homicides. Another officer said that they did not take a video since the death was not regarded as suspicious. He said that it 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.

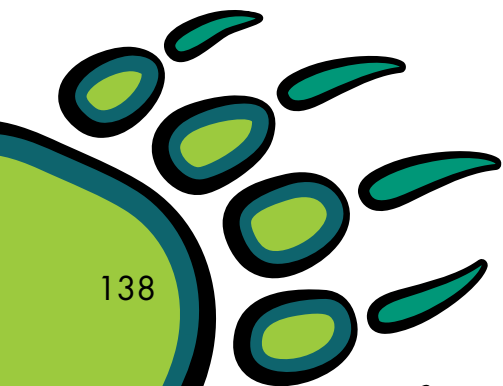
In the cases of M.N. and S.T., the coroner's jury determined the "means of death" was "undetermined." In the cases of O.P. and Q.R., the means of death was determined to be "accident."

## 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.

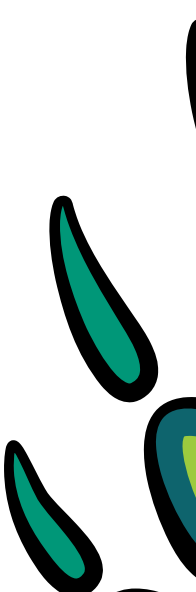
Timely investigations allow for a greater opportunity to obtain evidence and gain access to witnesses. Timely interviews make it more likely that witnesses will have much better memories of events, and are more likely to lead to successful outcomes in missing persons investigations.

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.



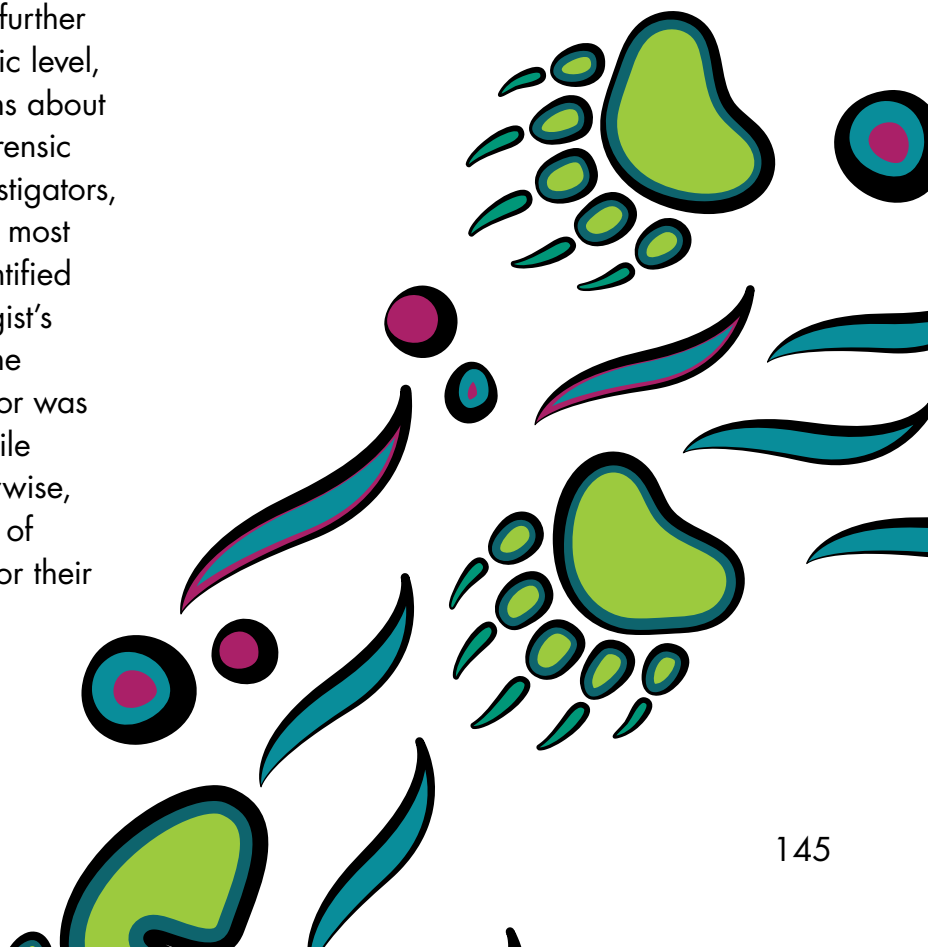
No documents indicate that any further investigation was done on this matter after O.P.'s body was found.

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.



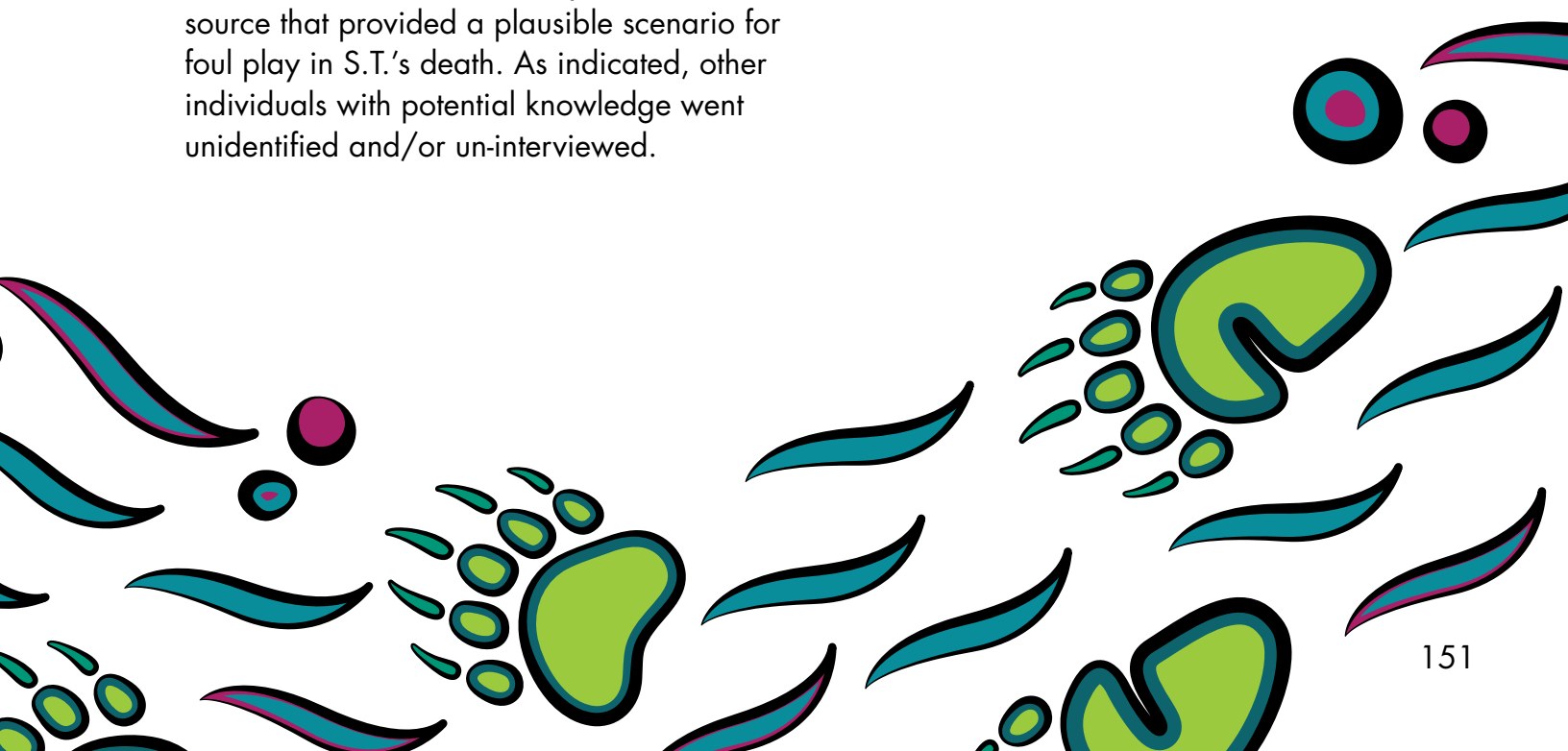
The police interviewed multiple individuals in connection with S.T.'s disappearance and death. However, it is very difficult to understand how the police concluded, even after the autopsy, that "in the absence of any other evidence, there is no reason to suspect foul play." The information that S.T. 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.

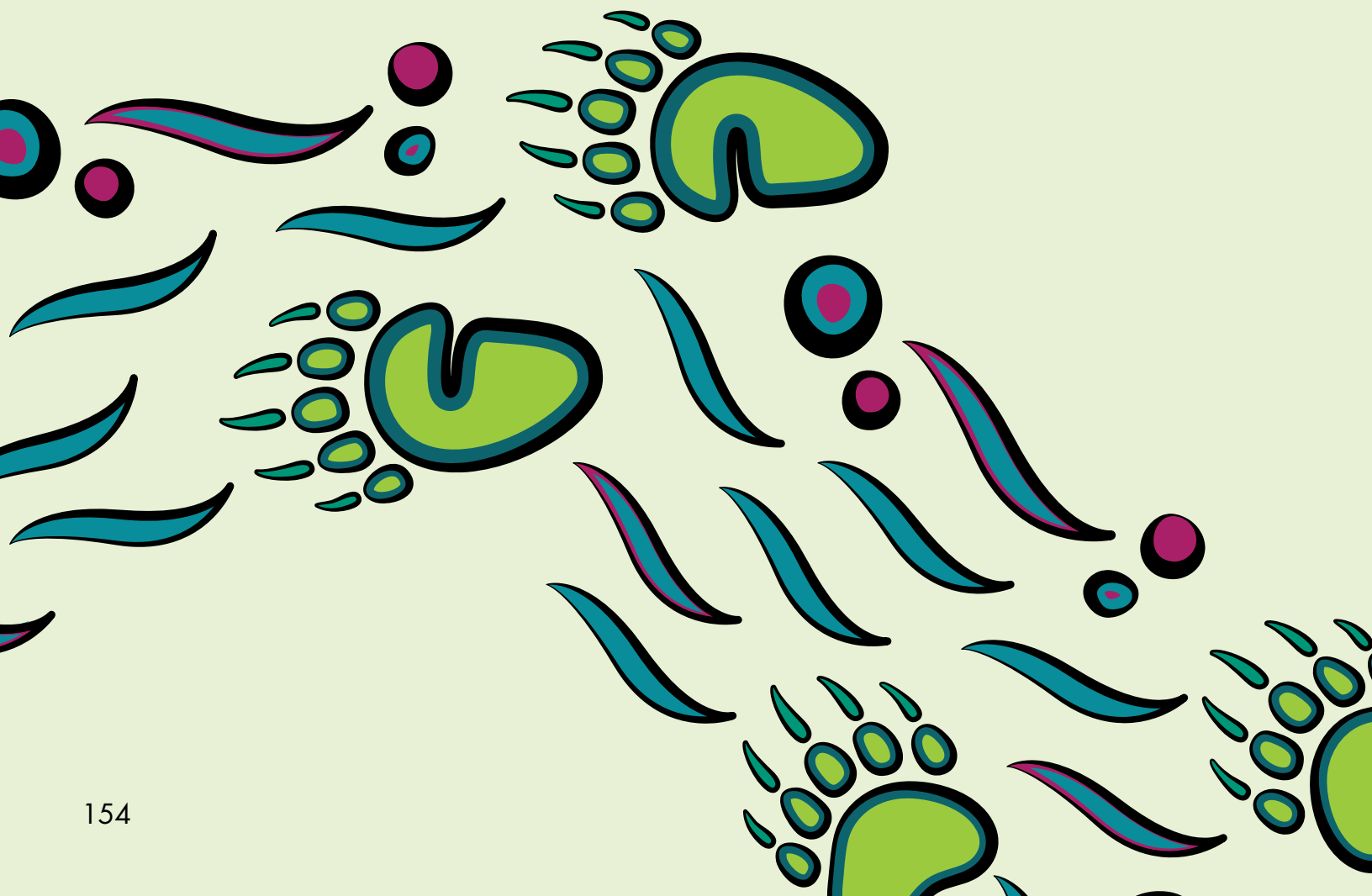
## **Josiah Begg**

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.

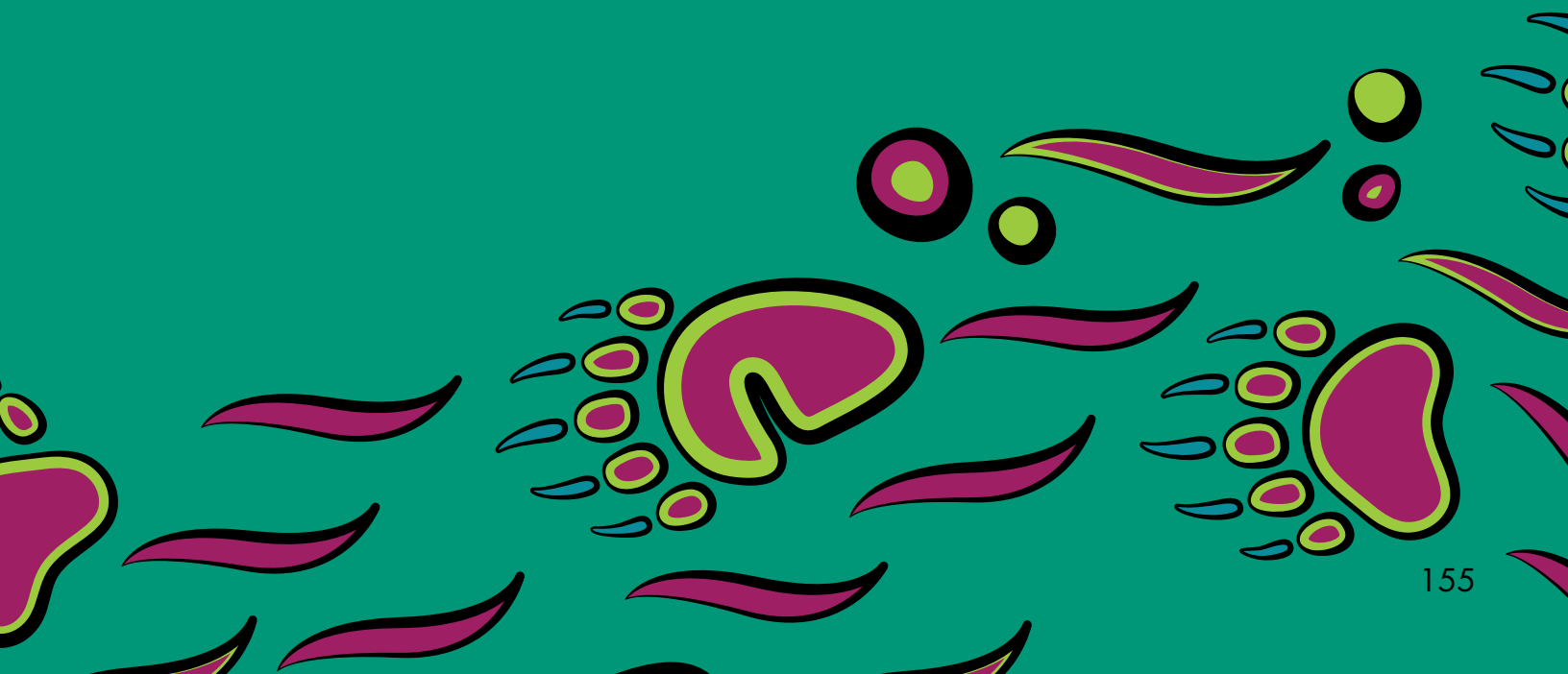
The Thunder Bay coroner's office initiated a death investigation with TBPS assisting with the investigation. In June 2017, the Chief Coroner for Ontario asked York Regional Police to assist TBPS with its investigation. YRP's investigation focused on interviewing witnesses. After a number of interviews 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
- **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

## 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

- 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.**

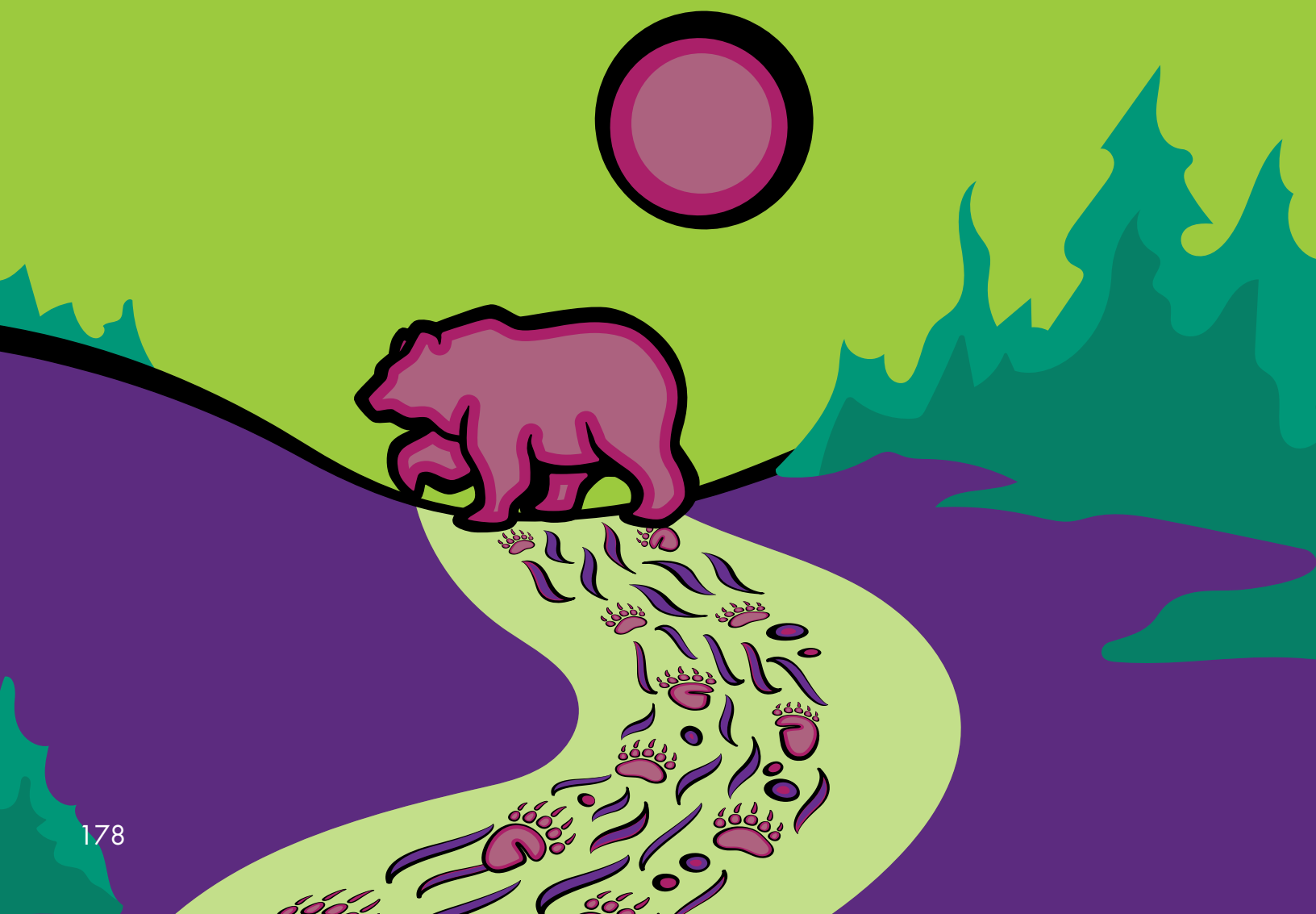
These challenges were identified by FIU officers, TBPS investigators and senior management and the Chief Forensic Pathologist.



# 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.

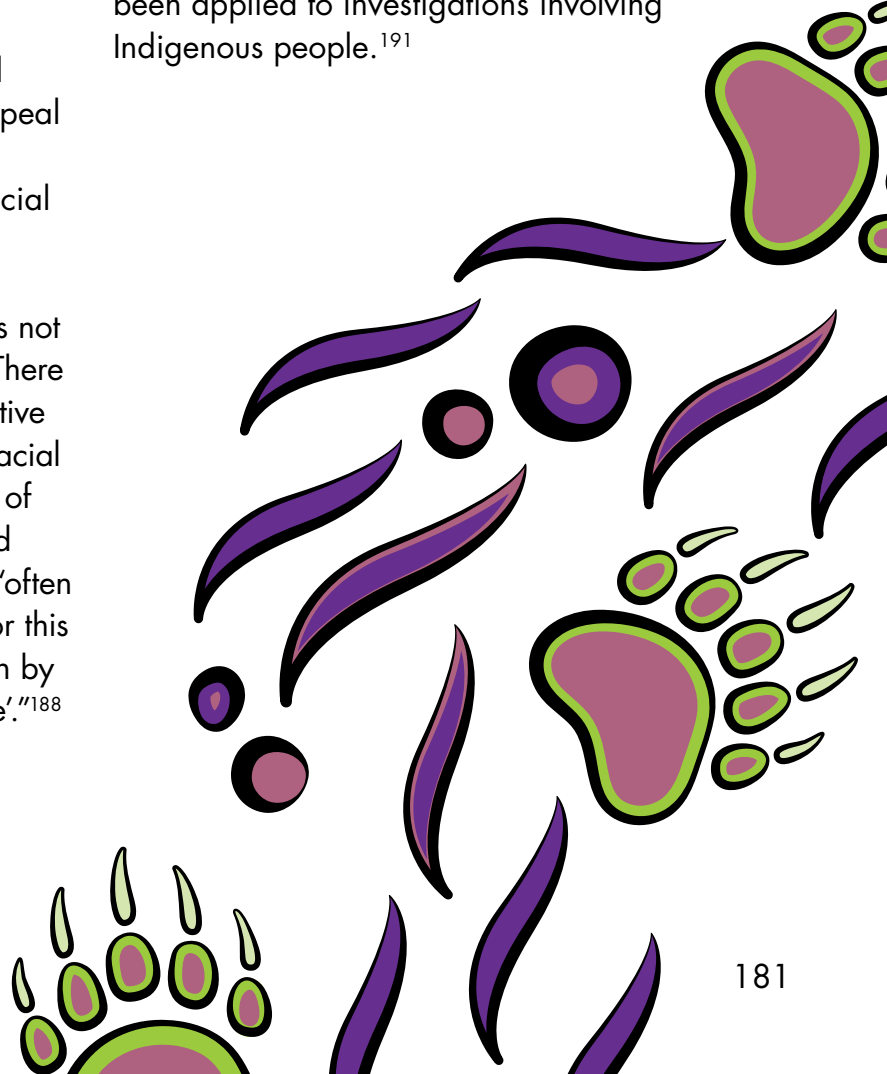
The courts have acknowledged that in this day and age, blatant forms of inter-personal discrimination are rather exceptional, and that subjective intent to treat someone unequally is not required to prove racial discrimination. Rather than searching for direct evidence of overtly racist statements or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



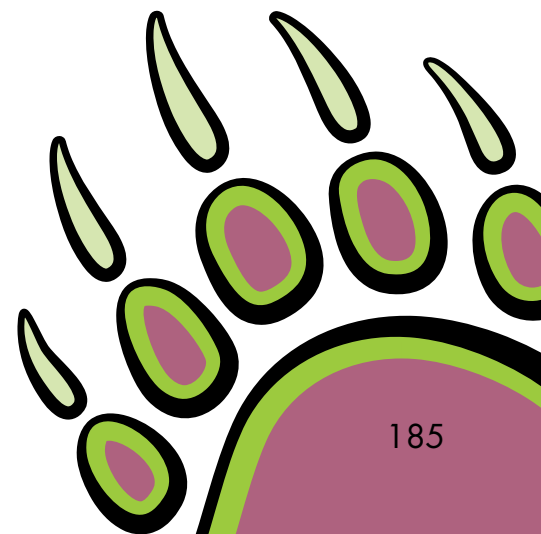
“What would I like to see? I’d like to see the federal government abolish all of the reserves and, not a forceful thing, but an option: “We’re gonna give you each a quarter of a million dollars and you can do with it what you want but from here on in, everybody’s the same and we’re gonna move forward 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.

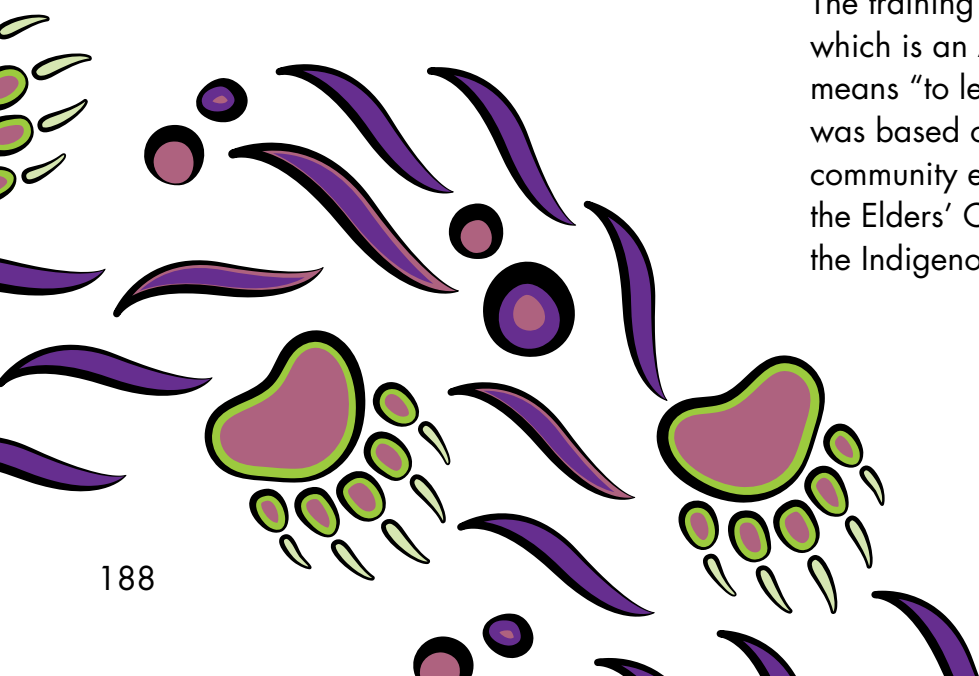
**36. TBPS should work with training experts, Indigenous leaders, Elders and the Ontario Ministry of the Attorney General’s Indigenous Justice Division to design and implement mandatory Indigenous cultural competency and anti-racism training for all TBPS officers and employees, that:**

- 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.**

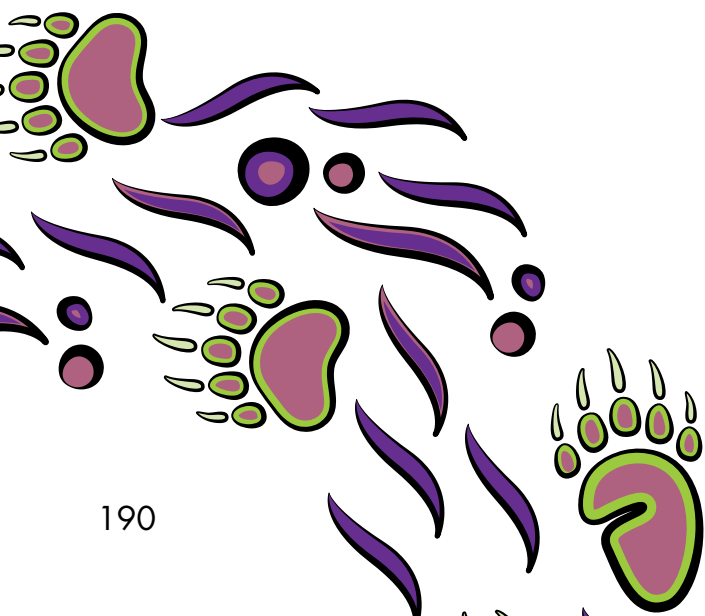
## RECOMMENDATIONS ON RACISM IN TBPS POLICING – RECRUITMENT AND JOB PROMOTION

### 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.

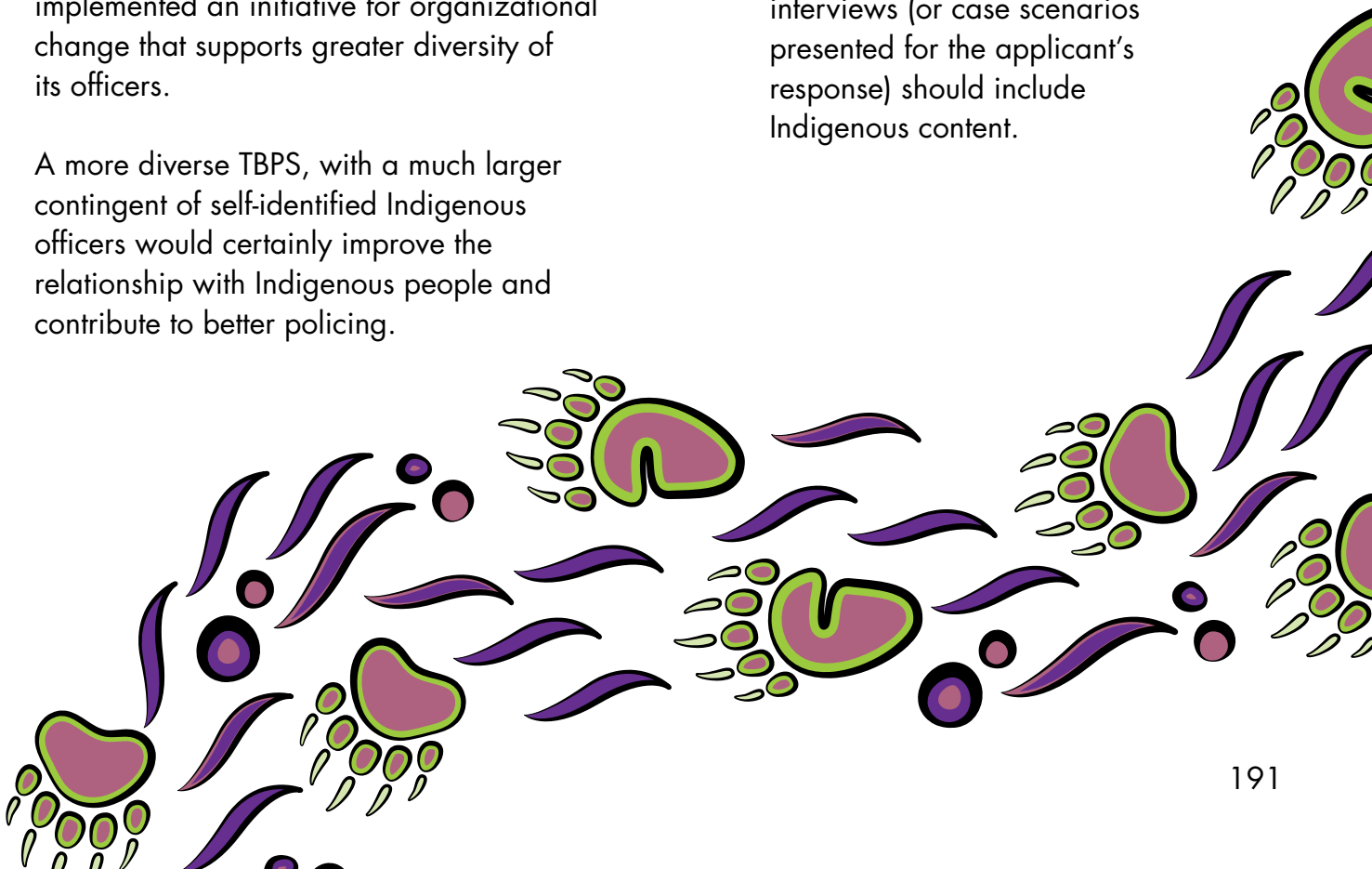
There has not been any strategy in place to recruit more Indigenous officers within the service. However, TBPS has indicated it has implemented an initiative for organizational change that supports greater diversity of its officers.

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.

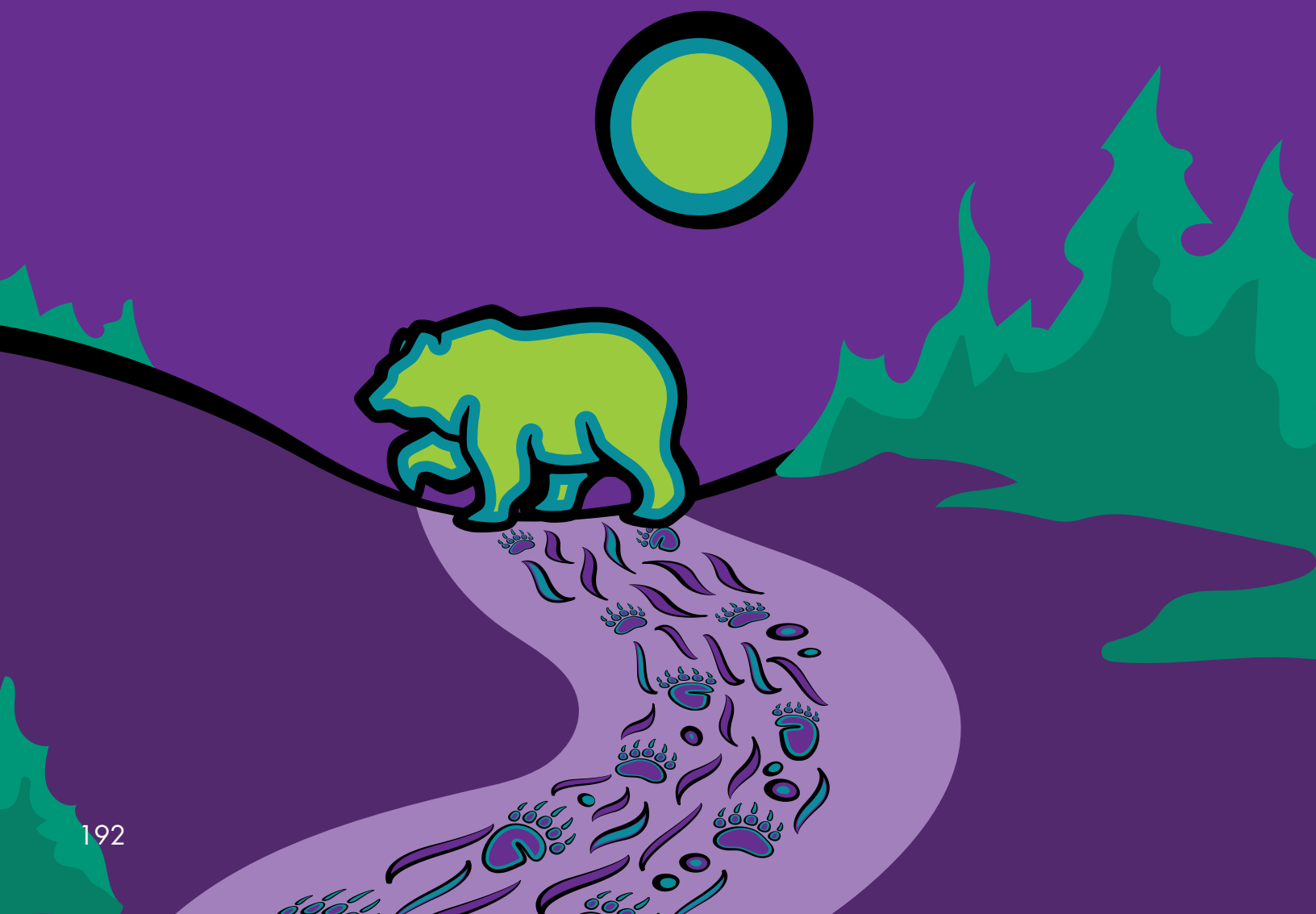
## Job Promotion

**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

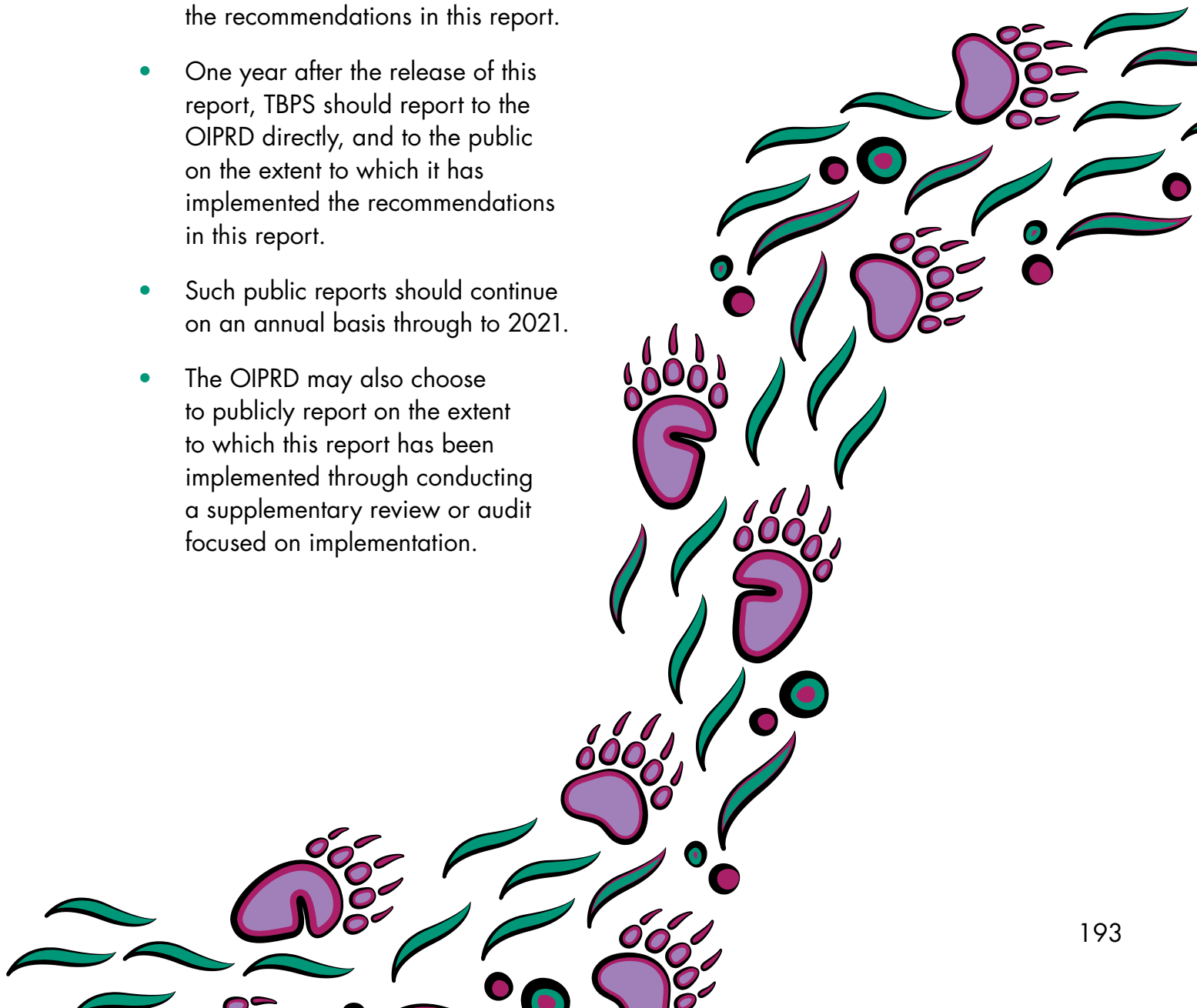




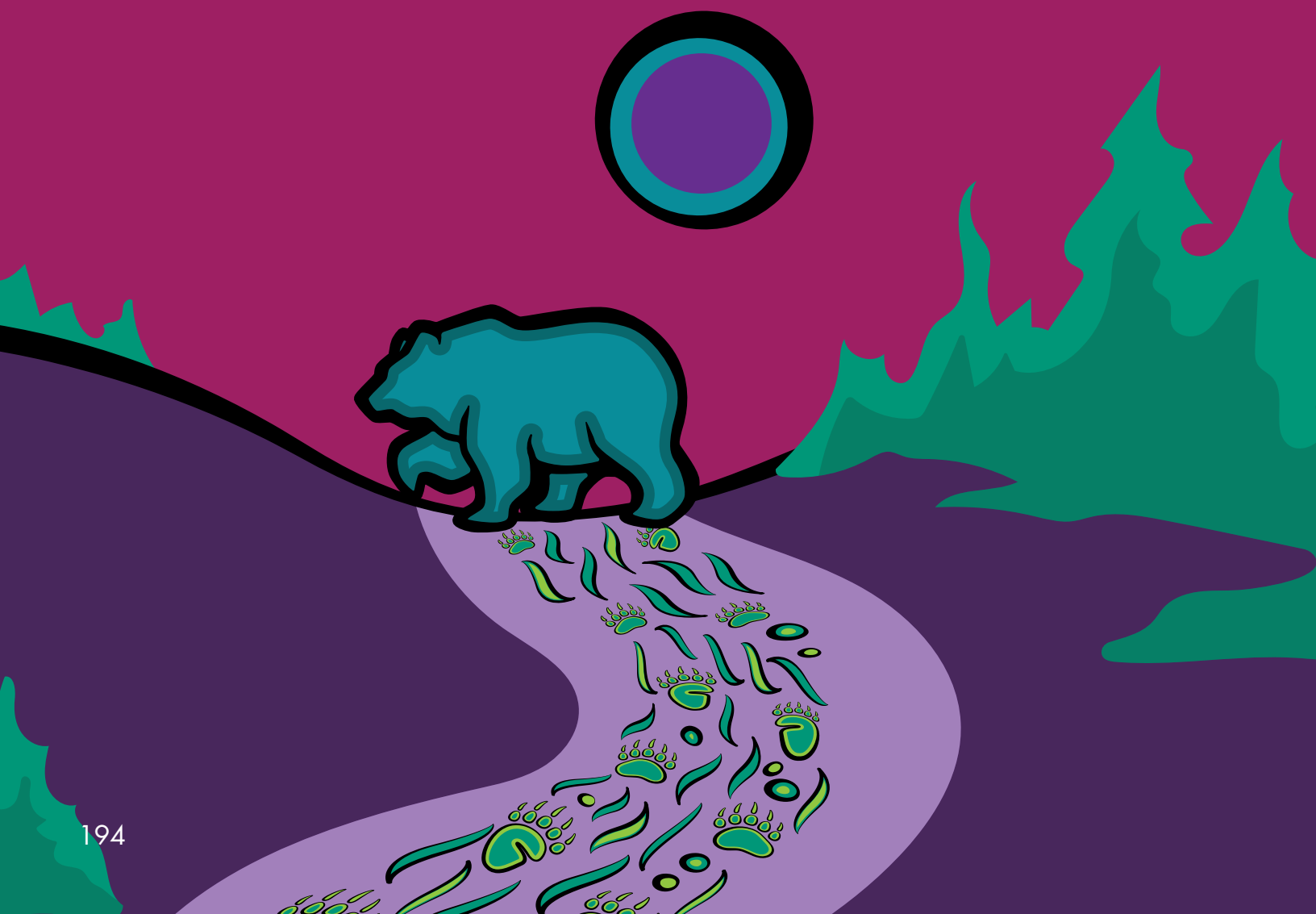
**43. Thunder Bay Police Service should report to the OIPRD on the extent to which the recommendations in this report are implemented. This is imperative given the crisis in confidence described in this report. The OIPRD should, in turn, report publicly on TBPS's response and the extent to which the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

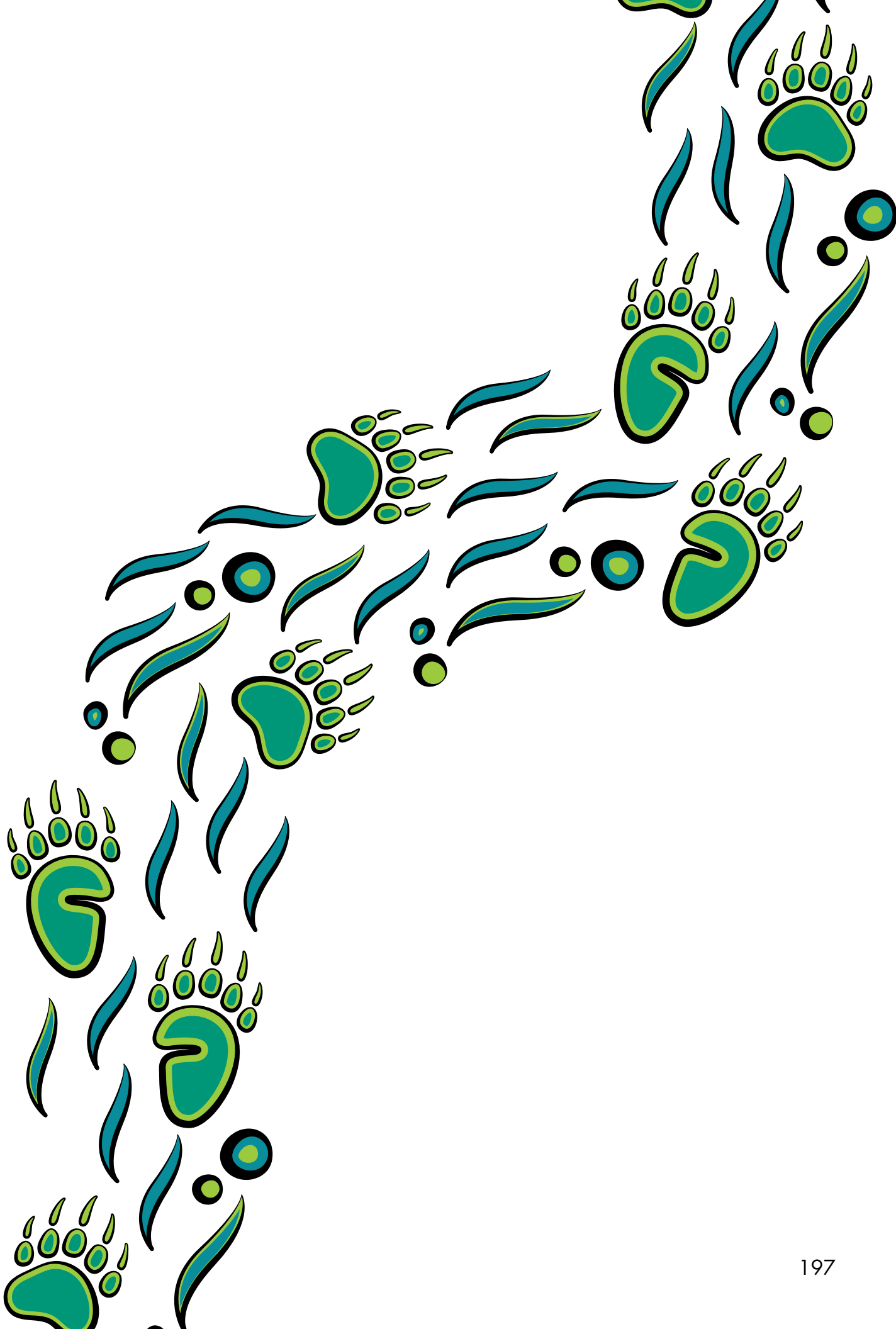
must be delivered in a respectful and positive environment and be relevant to how officers interact with Indigenous people on a day-to-day basis. It is important that Indigenous cultural competency and anti-racism figures prominently in promotional decisions – this means, among other things, that promotional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



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## Chapter 1

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## 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

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## 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>.

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<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.

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