



**RAINY RIVER
FIRST NATIONS**

BACKGROUND

On October 19, 2015, Stacy's body was found in the McIntyre River. Three hours after the discovery, the TBPS stated that "[a]n initial investigation does not indicate a suspicious death". In a second press release published just 25 hours after the discovery of his body, the TBPS released Stacy's name and declared that his "death has been deemed non-criminal".

As a result of the early determination of "no foul play" and subsequent failure of the TBPS to conduct a proper investigation into Stacy's death, his brother, Bradley DeBungee, and Former RRFN Chief Jim Leonard jointly submitted a Complaint to the OIPRD, which was officially retained by the OIPRD on April 22, 2016, alleging misconduct against the investigating officers and requesting a systemic review be conducted by the OIPRD.

Seven Youth Inquest

While Stacy's death was being investigated, the Seven Youth Inquest was ongoing. A common theme with these deaths: the investigations were substandard and there was a serious concern into an underlying racial issue for the substandard treatment. The very same issues that plagued Stacy's death investigation.

In recognition of this important background, the OIPRD found that "it was troubling that this inadequate investigation took place in the context of an ongoing coroner's inquest ... 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."¹

Misconduct Findings

1. Discreditable Conduct – Anti-Indigenous Racism

The OIPRD found that there is overwhelming evidence to support the allegation that Detective Harrison and Detective Constable Whipple prematurely concluded that Stacy rolled into the river and drowned without any external intervention. The OIPRD found that it can be reasonably inferred that this premature conclusion may have been drawn because Stacy was Indigenous.

¹ Office of the Independent Police Review Director Investigative Report: Brad DeBungee and Jim Leonard, February 15, 2018, at page 118 ["OIPRD Report"].

2. Neglect of Duty

The OIPRD highlight's major concerns within the operations of the TBPS. Specifically, there "appeared to be little or no formal process for how a lead investigator was assigned and very little supervision or oversight of the investigation thereafter. That reflected, among other things, a misconception of the nature of the sudden death investigation and organizational deficiencies."² Further, the OIPRD found that "at the time of the investigation, TBPS did not have a formal review process for ongoing death investigation. That raised obvious systemic issues."³

In addition, the Report raises serious concerns about the treatment by the TBPS of evidentiary information⁴ and its lack of evidence preservation⁵, its inability to build trust with family and witnesses in relation to a death investigation⁶, and the reliance on improper assumptions without supporting evidence.⁷ When describing the importance of "actually read[ing] the information pertaining to the investigation on an ongoing basis"⁸, the OIPRD found that the investigating officers failed in "basic policing"⁹ [see page 3 for full OIPRD quotes].

² *Ibid* at page 118

³ *Ibid* at page 122

⁴ *Ibid* at page 125

⁵ *Ibid* at page 114

⁶ *Ibid* at page 119

⁷ *Ibid* at page 105

⁸ *Ibid* at page 112

⁹ *Ibid*

OIPRD REPORT EXCERPTS- FAILINGS OF TBPS

- “there appeared to be little or no formal process for how a lead investigator was assigned and very little supervision or oversight of the investigation thereafter” (pg. 102);
- “several officers ... showed a deeply troubling misconception about what a criminal investigation entails” (pg. 103);
- “the evidence is clear that an evidence-based proper investigation never took place into SD’s sudden death while Detective Harrison led what little investigation took place. Deputy Chief Hay’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” (pg. 104);
- “In the interviews conducted with the OIPRD investigators, the TBPS investigators demonstrated how poorly they understood their responsibilities in this sudden death investigation” (pg. 106);
- “The fact that they did not know one way or the other whether it was a criminal event supported the importance of doing a thorough criminal investigation – not the contrary” (pg. 107);
- “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 invidious who were with the deceased the night before he was found” (pg. 108);
- “the media releases undermined confidence in any criminal investigation which followed which should have been foreseeable by Detective Harrison in light of the existing issues between TBPS and Indigenous people” (pg. 110);
- “Detective Harrison’s decision not to meet with the private investigator further contributed to the family’s reasonably held belief that the matter was not being taken sufficiently seriously” (pg. 117);
- “the deficiencies in the investigation were so substantial – and deviated so significantly from what was required as to provide reasonable and probable grounds to support an allegation of neglect of duty” (pg. 118);
- “This was not a situation in which TBPS investigators faced non-cooperation when they interviewed Indigenous witnesses. Instead, they failed to follow up with identified witnesses in an adequate or timely way. In any event, police must be proactive in building trust in relation to each investigation. Little or none of that occurred here” (pg. 119).
- “There appeared to be little or no formal process for assigning a lead investigator...”
- “At the time of the investigation, TBPS did not have a formal review process for ongoing death investigations. That raised obvious systemic issues” (pg. 122);
- POST SCRIPT: there are serious concerns about the treatment by TBPS of information pertaining to HH’s alleged confession – initial information received on May 12, 2016, and 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 (pg. 125).