SPECIAL INVESTIGATIONS UNIT

DIRECTOR'S REPORT

CASE # 24-OCD-482

March 7, 2025

MANDATE OF THE SIU

The Special Investigations Unit is a civilian law enforcement agency that investigates incidents involving an official where there has been death, serious injury, the discharge of a firearm at a person or an allegation of sexual assault. Under the *Special Investigations Unit Act, 2019* (SIU Act), officials are defined as police officers, special constables of the Niagara Parks Commission and peace officers under the *Legislative Assembly Act*. The SIU's jurisdiction covers more than 50 municipal, regional and provincial police services across Ontario.

Under the *SIU Act*, the Director of the SIU must determine based on the evidence gathered in an investigation whether there are reasonable grounds to believe that a criminal offence was committed. If such grounds exist, the Director has the authority to lay a criminal charge against the official. Alternatively, in cases where no reasonable grounds exist, the Director cannot lay charges. Where no charges are laid, a report of the investigation is prepared and released publicly, except in the case of reports dealing with allegations of sexual assault, in which case the SIU Director may consult with the affected person and exercise a discretion to not publicly release the report having regard to the affected person's privacy interests.

INFORMATION RESTRICTIONS

Special Investigations Unit Act, 2019

Pursuant to section 34, certain information may not be included in this report. This information may include, but is not limited to, the following:

- The name of, and any information identifying, a subject official, witness official, civilian witness or affected person.
- Information that may result in the identity of a person who reported that they were sexually assaulted being revealed in connection with the sexual assault.
- Information that, in the opinion of the SIU Director, could lead to a risk of serious harm to a person.
- Information that discloses investigative techniques or procedures.
- Information, the release of which is prohibited or restricted by law.
- Information in which a person's privacy interest in not having the information published clearly outweighs the public interest in having the information published.

Freedom of Information and Protection of Personal Privacy Act

Pursuant to section 14 (*i.e., law enforcement*), certain information may not be included in this report. This information may include, but is not limited to, the following:

- Confidential investigative techniques and procedures used by law enforcement agencies; and
- Information that could reasonably be expected to interfere with a law enforcement matter or an investigation undertaken with a view to a law enforcement proceeding.

Pursuant to section 21 (*i.e., personal privacy*), protected personal information is not included in this report. This information may include, but is not limited to, the following:

- The names of persons, including civilian witnesses, and subject and witness officials;
- Location information;
- Witness statements and evidence gathered in the course of the investigation provided to the SIU in confidence; and
- Other identifiers which are likely to reveal personal information about individuals involved in the investigation.

Personal Health Information Protection Act, 2004

Pursuant to this legislation, any information related to the personal health of identifiable individuals is not included.

Other proceedings, processes, and investigations

Information may also have been excluded from this report because its release could undermine the integrity of other proceedings involving the same incident, such as criminal proceedings, coroner's inquests, other public proceedings and/or other law enforcement investigations.

MANDATE ENGAGED

Pursuant to section 15 of the SIU Act, the SIU may investigate the conduct of officials, be they police officers, special constables of the Niagara Parks Commission or peace officers under the *Legislative Assembly Act*, that may have resulted in death, serious injury, sexual assault or the discharge of a firearm at a person.

A person sustains a "serious injury" for purposes of the SIU's jurisdiction if they: sustain an injury as a result of which they are admitted to hospital; suffer a fracture to the skull, or to a limb, rib or vertebra; suffer burns to a significant proportion of their body; lose any portion of their body; or, as a result of an injury, experience a loss of vision or hearing.

In addition, a "serious injury" means any other injury sustained by a person that is likely to interfere with the person's health or comfort and is not transient or trifling in nature.

This report relates to the SIU's investigation into the death of a 26-year-old man (the "Complainant").

THE INVESTIGATION

Notification of the SIU[1]

On November 12, 2024, at 5:26 a.m., the Durham Regional Police Service (DRPS) notified the SIU of the death of the Complainant.

According to the DRPS, at 3:37 a.m., the DRPS received a call from Civilian Witness (CW) #1, reporting that the Complainant was threatening suicide at the Lakeridge Health Oshawa (LHO). CW #1 had taken the Complainant to the hospital because he had self-harmed. When police officers arrived at 3:44 a.m., they found the Complainant on top of the parking garage [7th floor – rooftop]. Witness Official (WO) #1, the Subject Official (SO), WO #2 and WO #3 were present on the parking garage roof. At 4:33 a.m., the Complainant jumped to his death.

The Team

Date and time team dispatched:	2024/11/12 at 5:52 a.m.
Date and time SIU arrived on scene:	2024/11/12 at 8:15 a.m.
Number of SIU Investigators assigned:	3
Number of SIU Forensic Investigators assigned:	2

[1] Unless otherwise specified, the information in this section reflects the information received by the SIU at the time of notification and does not necessarily reflect the SIU's findings of fact following its investigation.

Affected Person (aka "Complainant"): 26-year-old male; deceased

*[**Note:** An affected person (complainant) is an individual who was involved in some form of interaction with an official or officials, during the course of which the individual sustained serious injury, died, was reported to have been sexually assaulted, or was shot at by a firearm discharged by an official.]*

Civilian Witnesses (CW)

CW #1	Interviewed
CW #2	Interviewed
CW #3	Interviewed
CW #4	Interviewed
CW #5	Interviewed
CW #6	Interviewed

The civilian witnesses were interviewed between November 12 and 19, 2024.

Subject Official (SO)

SO	Declined interview and to provide notes, as is the subject official's legal right

*[**Note:** A subject official is an official (whether a police officer, a special constable of the Niagara Parks Commission or a peace officer with the Legislative Protective Service) whose conduct appears, in the opinion of the SIU Director, to have been a cause of the incident under investigation.*

Subject officials are invited, but cannot be legally compelled, to present themselves for an interview with the SIU and they do not have to submit their notes to the SIU pursuant to the SIU Act.]

Witness Officials (WO)

WO #1	Interviewed; notes received and reviewed
WO #2	Interviewed; notes received and reviewed
WO #3	Interviewed; notes received and reviewed
WO #4	Not interviewed; notes reviewed and interview deemed unnecessary

The witness officials were interviewed on November 15, 2024.

*[**Note:** A witness official is an official (whether a police officer, a special constable of the Niagara Parks Commission or a peace officer with the Legislative Protective Service) who, in the opinion of the SIU Director, is involved in the incident under investigation but is not a subject official in relation to the incident.*

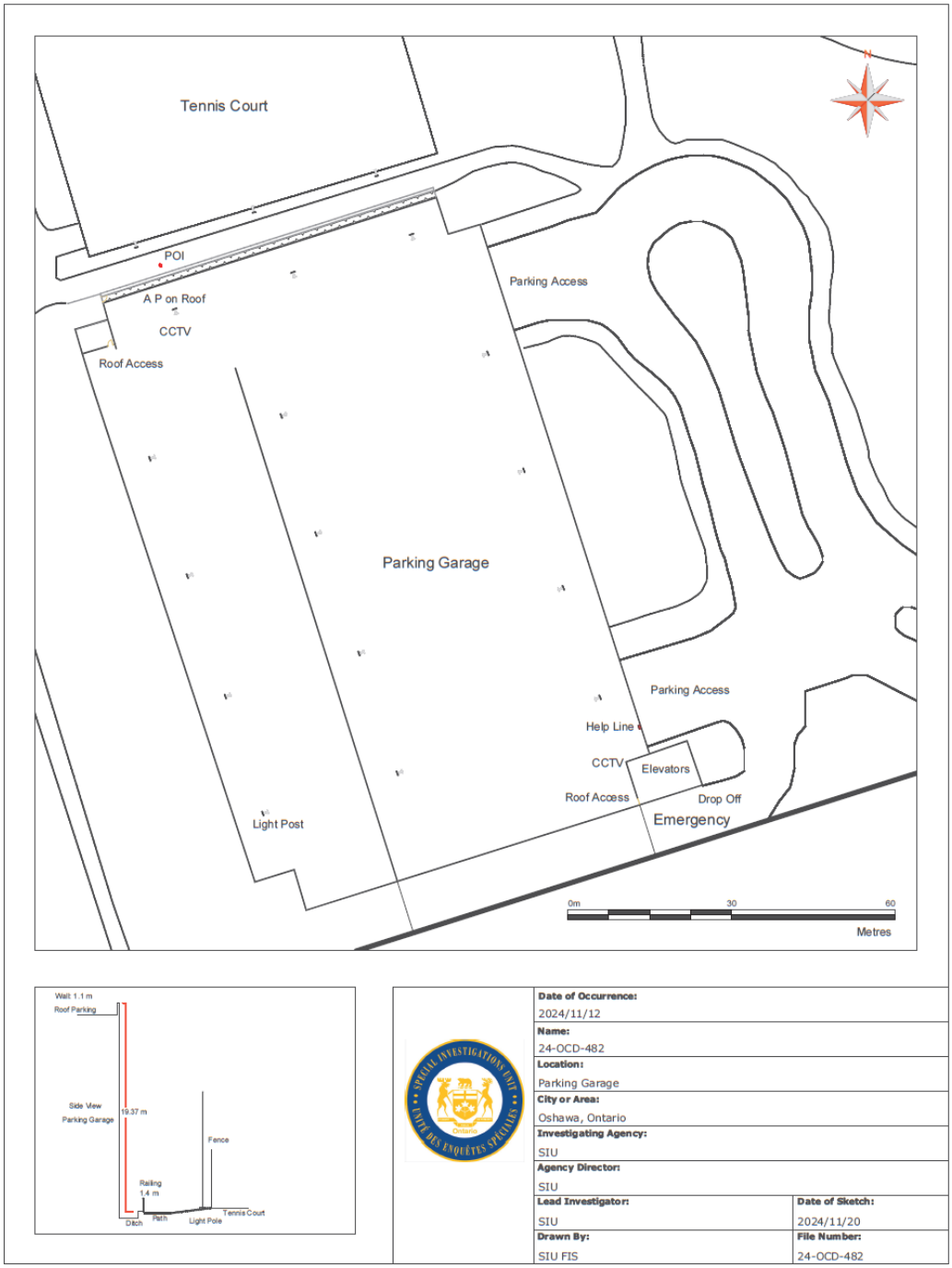
Upon request by the SIU, witness officials are under a legal obligation pursuant to the SIU Act to submit to interviews with SIU investigators and answer all reasonable questions. The SIU is also entitled to a copy of their notes.]

EVIDENCE

The Scene

The events in question transpired on the seventh-floor open roof of the parking garage of Lakeridge Health Oshawa, Hospital Court, Oshawa.

Scene Diagram



Physical Evidence

On November 12, 2024, at 9:10 a.m., a SIU forensic investigator arrived at the incident scene, located at the north side of the parking garage. The weather was clear and cool, at three degrees Celsius. The parking garage was located towards the north side of the hospital. There were two vehicle access locations, towards the north and south ends, both on the east side. Two stairwells were within the garage. One was at the southeast corner. This also housed a bank of three elevators. The other stairwell was at the northwest corner.

The lower door of the northwest stairs was designed for exit only, and it opened onto a grassed area with a path. At the north side of the garage, a tarmac paved access path bordered the garage wall. It was separated from the garage wall by a drainage ditch with a retaining wall and metal railing. The ditch was 1.78 metres wide and ran along the side of the garage with a gated opening at the west end. It was closed off at the east end. The railing was affixed to the top of the retaining wall, 0.7 metres above the bottom of the ditch. It was 1.4 metres in height from the top of the railing to the path. To the north side of the path was a fence which ran the width of the parking garage. On the paved path was an area of pooled staining, which was measured as being 3.5 metres from the north wall of the garage.

The Complainant and the police officers interacted on the north side, near the northwest stairwell of the parking garage. The surrounding wall, along the north side of the parking area, was 1.1 metres in height. The distance from the top of this wall to the area of staining on the path below was measured to be 19.37 metres.

The area was photographed and measured.

Video/Audio/Photographic Evidence[2]

Body-worn Camera (BWC) Footage

On November 12, 2024, starting at about 3:44 a.m., WO #3 and WO #2, and security guards from LHO, ran to a corner of a parking level [now known to be the northwest corner of the rooftop parking garage – seventh-floor - of LHO]. The Complainant stood on the concrete perimeter wall. CW #1stood approximately 1.5 metres to three metres from the Complainant. WO #3 stated, "…. speak to us." The Complainant replied, "Where do I start?" WO #3 asked the Complainant to get down. The officer said he would keep his distance and CW #1 would back up. The Complainant stated he would maybe get down.

Starting at about 3:45 a.m., the SO arrived and engaged the Complainant in conversation, subsequently becoming the lead negotiator with the Complainant. The Complainant said he had no life, and no outlook. The SO established a measure of rapport with the Complainant, sharing her own struggles. There was a collective effort by all the attending DRPS police officers to assure him that they were there to provide help, and that there was a future for him.

The Complainant was asked numerous times by the SO to come down off the wall so they could talk and go for a coffee. He declined to step down. At about 4:33 a.m., the Complainant took two steps and walked off the ledge.

WO #3 and other officers ran to ground level where the Complainant had landed on a paved surface at the back of the parking garage. The police officers assisted paramedics. The Complainant was taken into the ambulance, which was parked at the rear of the parking garage, and WO #1 performed CPR.

[2] The following records contain sensitive personal information and are not being released pursuant to section 34(2) of the *Special Investigations Unit Act, 2019.* The material portions of the records are summarized below.

Communications Recordings

On November 12, 2024, at 3:37 a.m., the DRPS received a 911 call from CW #1, reporting that she was at the top of the parking garage at LHO with the Complainant, who was going to commit suicide by jumping. CW #1 cried on the telephone and shouted at the Complainant to get down. WO #1, WO #2, WO #3 and the SO were dispatched. The Complainant could be heard in the background, but the call-taker could not make out what was said. A police officer asked dispatch to contact the security at the hospital. CW #1 identified the Complainant and provided information about his medical history. CW #1 did not know if the Complainant would be cooperative with police, and she stated that this was out of character for him.

At 3:44 a.m., WO #3 advised dispatch that the Complainant was in the northeast [now known to be northwest] corner of the top floor, on the ledge, and he looked like he was motivated to jump.

At 4:33 a.m., WO #4 advised that the Complainant had jumped.

Materials Obtained from Police Service

Upon request, the SIU obtained the following records from the DRPS between November 12, 2024, and November 14, 2024:

- BWC footage
- Communications recordings
- Directive - Persons in Crisis, and Attempted Suicide
- Detailed Call Summary
- General Occurrence Information
- Civilian Witness List
- Notes – WO #2, WO #3, WO #1, and WO #4
- Police Witness Reports – WO #2 and WO #3
- General Occurrence Report - WO #1
- Involved Officer List

Materials Obtained from Other Sources

The SIU obtained the Preliminary Autopsy Findings Report from the Ontario Forensic Pathology Service on November 15, 2024.

INCIDENT NARRATIVE

The evidence collected by the SIU, including interviews with police and civilian witnesses, and video footage that captured the incident, gives rise to the following scenario. As was her legal right, the SO did not agree an interview with the SIU or the release of her notes.

In the early morning of November 12, 2024, the DRPS received a 911 call from CW #1. CW #1 explained that she had driven the Complainant to Lakeridge Health Oshawa after he

had self-harmed. The Complainant was on the open rooftop parking level (seventh-floor) and threatening to commit suicide by jumping.

WO #2 and WO #3, in the company of several hospital security staff, were the first on scene, arriving at about 3:44 a.m. By this time, the Complainant was standing on the ledge of the concrete perimeter wall around the rooftop. The officers approached the Complainant in the northwest corner of the rooftop and WO #3 asked him to come down to safety. The Complainant remained on the wall.

The SO, together with WO #1, arrived at about 3:45 a.m. and took the lead in communicating with the Complainant. Over the course of the next 45 minutes or so, from a distance of about two to three metres, the SO attempted to convince the Complainant to come down off the ledge. The Complainant shared with the officer his feelings of hopelessness. The SO empathized with the Complainant and talked about some of her own struggles. She assured the Complainant that things would be different and he could be helped. The Complainant refused to step back onto the rooftop. At about 4:33 a.m., he walked off the ledge and fell to the ground below.

Officers and paramedics tended to the Complainant. He was subsequently pronounced deceased.

Cause of Death

The pathologist at autopsy was of the preliminary view that the Complainant's death was attributable to multiple blunt force trauma.

RELEVANT LEGISLATION

Sections 219 and 220, *Criminal Code* - Criminal Negligence Causing Death

219 (1) Every one is criminally negligent who

(a) in doing anything, or
(b) in omitting to do anything that it is his duty to do,

shows wanton or reckless disregard for the lives or safety of other persons.

(2) For the purposes of this section, *duty* means a duty imposed by law.

220 Every person who by criminal negligence causes death to another person is guilty of an indictable offence and liable
(a) where a firearm is used in the commission of the offence, to imprisonment for life and to a minimum punishment of imprisonment for a term of four years; and
(b) in any other case, to imprisonment for life.

ANALYSIS AND DIRECTOR'S DECISION

The Complainant died on November 12, 2024, the result of a fall from height. As DRPS officers were engaging with the Complainant at the time, the SIU was notified of the incident and initiated an investigation. The SO was identified as the subject official. The investigation is now concluded. On my assessment of the evidence, there are no reasonable grounds to believe that the SO committed a criminal offence in connection with the Complainant's death.

The offence that arises for consideration is *criminal negligence causing death* contrary to section 220 of the *Criminal Code*. The offence is reserved for serious cases of neglect that demonstrate a wanton or reckless disregard for the lives or safety of other persons. It is predicated, in part, on conduct that amounts to a marked and substantial departure from the level of care that a reasonable person would have exercised in the circumstances. In the instant case, the question is whether there was a want of care on the part of the SO, sufficiently egregious to attract criminal sanction, that caused or contributed to the Complainant's death. In my view, there was not.

The SO and the other officers who responded to the parking garage rooftop were pursuing their lawful duties through the course of events that culminated in the Complainant's death. An officer's foremost obligation being the preservation of life, they were within their rights in attending at the scene to do what they reasonably could to prevent harm coming to the Complainant.

I am also satisfied that the SO comported herself with due care and regard for the Complainant's wellbeing throughout their time. From a distance of two to three metres, so as not to provoke him, the officer spoke to the Complainant with compassion and reassurance. She did what she could to win his trust and convince him to return to safety, engaging him on what he liked and sharing some of her own life story. While the Complainant was receptive to the SO, he could not be dissuaded. Without any warning, the Complainant walked off the ledge leaving the SO and the other officers no chance of physically intervening to prevent that happening. On this record, while the officers were unable to prevent the Complainant's tragic death, it was not from any want of reasonable efforts on their part.

For the foregoing reasons, there is no basis for proceeding with criminal charges in this case. The file is closed.

Date: March 7, 2025

Joseph Martino
Director
Special Investigations Unit