2024 CarswellOnt 5204
Ontario Coroner

Thomson, Re

2024 CarswellOnt 5204

Inquest into the Death of David Bartholomew THOMSON

Selwyn A. Pieters Presiding Officer

Heard: March 18, 2024; March 19, 2024; March 20, 2024
Judgment: April 10, 2024
Docket: None given.

Proceedings: additional reasons to *Thomson, Re* (March 20, 2024), Selwyn Pieters Presiding Officer (Ont. Coroner)

Counsel: Maria Stevens, Shruti Ramesh — Inquest Counsel
Corbin Cawkell, for Lee Doolittle
Gary Clewley, for Hamilton Police Officers, Supr. Mark Stiller, Sgt. David Spencer, Det. Andrew Coughlan, Sgt. Alan Ing
Marco Visentini, for Hamilton Police Service Chief and Hamilton Police Service Board

Subject: Civil Practice and Procedure
Related Abridgment Classifications
Judges and courts
VII Coroners
VII.2 Coroner's inquest
VII.2.b Practice and procedure
VII.2.b.ix Verdict or inquisition
VII.2.b.ix.B Explanation of verdict
Headnote
Judges and courts --- Coroners — Coroner's inquest — Practice and procedure — Verdict or inquisition — Explanation of verdict
Verdict explanation following inquest into death of Indigenous person.
Table of Authorities
Statutes considered:
Coroners Act, R.S.O. 1990, c. C.37
s. 10

s. 31(1)

s. 31(3)

***Selwyn A. Pieters Presiding Officer*:**

OPENING COMMENT

1 This verdict explanation is intended to give the reader a brief overview of the circumstances surrounding the death of David Thomson along with some context for the verdict reached by the jury. The synopsis of events and comments are based on the evidence presented and written to assist in understanding the jury's basis for no recommendations.

PARTICIPANTS

2

Inquest Counsel:	Maria Stevens, Counsel Office of the Chief Coroner 25 Morton Shulman Avenue Toronto, ON M3M 0B1 Shruti Ramesh, Counsel Indigenous Justice Division Ministry of the Attorney General 720 Bay Street Floor 4 Toronto, ON M7A 2S9
Inquest Investigator and Constable:	Detective Constable Jennifer Reid Ontario Provincial Police Provincial Inquest Unit 25 Morton Shulman Avenue Toronto, ON M3M 0B1
Recorder:	Wintana Paulos First Class Conferencing Facilitation Inc. 61-1035 Victoria Road S Guelph ON N1L0H5
Parties with Standing: **Lee Doolittle** **(Father of Mr. Thomson)**	**Represented by:** Corbin Cawkell, Counsel 1 Dundas St. West., Unit 2552 Toronto, ON M5G 1Z1 corbincawkell@gmail.com
Hamilton Police Officers **Supr. Mark Stiller** **Sgt. David Spencer** **Det. Andrew Coughlan** **Sgt. Alan Ing** **Hamilton Police Service Chief and Hamilton Police Service Board**	Gary Clewley, Counsel Gary R Clewley Legal Pro Corporation 360 Walmer Road Toronto, ON M5R 2Y4 garyclewley@rogers.com Marco Visentini, Counsel City of Hamilton Police 155 King William St. Hamilton, ON L8R 1A7 mvisentini@hamiltonpolice.ca

SUMMARY OF THE CIRCUMSTANCES OF THE DEATH

3 David Thomson, aged 33 years, was an Indigenous man. He was the father of a ten-year old son. It was reported to police that Mr. Thomson may be suffering from a serious illness and had expressed thoughts of suicide on the day he died.

4 Mr. Thomson was a suspect and wanted by Hamilton Police Service for the November 2, 2019, double murder of two Hamilton residents, Donald Lowe, 62, and Cheryl Nicholl, 32.

5 On November 3, 2019, Hamilton Police Service began searching for Mr. Thomson so that they could arrest him. A search warrant was executed at a home in Hamilton associated with Mr. Thomson, but he was not located. Police then received information that the vehicle Mr. Thomson had last been driving was seen in Brantford. Hamilton Police Officers from various units, including Intelligence, attended Brantford. Mr. Thomson's father, Lee Doolittle, was located with the car and taken to the police station for questioning. Mr. Doolittle provided the location of Mr. Thomson to Hamilton Police and officers attended the Days Inn at 460 Fairview Drive in Brantford to arrest Mr. Thomson.

6 A team of Emergency Response Unit (ERU) officers from Hamilton Police Service attended the hotel based on information received that Mr. Thomson was at that location, was suicidal, and had two handguns on him. An Incident Commander, Superintendent Mark Stiller, who was an inspector at the time, attended Brantford shortly after 9:00 p.m. and was at a Command Post.

7 Sgt. David Spencer was the ERU team tactical commander. Sgt. Allan Ing, who was a constable at the time, was part of that team.

8 Late into the evening, Officer Alan Ing tried to contact Mr. Thomson by "loud hailing" (calling out with his voice), directing Mr. Thomson to surrender himself. Officer Ing testified that he voiced out twice "David Thomson in Room 112, this is the Hamilton Police emergency response unit, come to the door with nothing in your hands ... do it now."

9 Within a minute after the voice out, police heard what they thought was a gunshot from inside the room. The police continued the call out process to ensure that it was not a ruse to get them to rush into the room or engage in a firefight with him. Police attempted to access the room using a keycard; however, it did not work. They subsequently breached the door manually.

10 When the police gained access to the room in which Mr. Thomson was staying, he was found dead with a self-inflicted gunshot wound to the head. A handgun was located beside him.

11 In Mr. Thomson's room was his luggage, a large quantity of cash and a large quantity of illicit drugs. Two pairs of handcuffs were also found in the room.

12 The jury heard evidence about the specialized training provided to the involved officers, including training on high-risk arrests, crisis negotiation and communicating with emotionally volatile subjects. The responding officers' mission was to make an arrest while prioritizing the safety of all involved. A witness from the Ontario Police College testified about the key skills taught to officers dealing with high-risk arrests. The training received by the involved Hamilton Police Service officers was the same as that provided by the Ontario Police College.

THE INQUEST

13 Dr. Karen Schiff, Regional Supervising Coroner for West Region, Hamilton Office, called a mandatory inquest into the death of David Thomson pursuant to section 10 of the *Coroners Act*.

14 The document outlining the scope of this inquest is attached as an Appendix.

15 The inquest was conducted in a virtual manner, with remote participation by parties with standing and remote testimony from all witnesses. In keeping with the open court principle, the inquest was streamed live.

16 The jury sat for three days, heard evidence from six witnesses, reviewed eight exhibits, and deliberated for one hour in reaching a verdict.

VERDICT

17

Name of Deceased:	David Bartholomew Thomson
Date and Time of Death:	03 November 2019 at 11:55 p.m.
Place of Death:	Days Inn, 460 Fairview Drive Brantford, Ontario
Cause of Death:	Gun shot wound of head with skull fractures, intracranial haemorrhage and disruption of brain matter

By What Means: Suicide

RECOMMENDATIONS

18 Section 31(3) encourages the jury to make recommendations. It reads:

> *"Subject to subsection (2) the jury may make recommendations directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest."*

19 I explained to the jury that "the verdict also gives you an opportunity to make recommendations — which may be addressed to organizations, governments, ministries and other relevant bodies — and these recommendations will be aimed at preventing further deaths. You do not have to make recommendations, but that option is there for you if you chose to."

20 In this case, the jury made no recommendations having considered all of the circumstances.

21 Corbin Cawkell, counsel for Mr. Thomson's father, Lee Doolittle, told the jury in his closing arguments he no longer believed anything should have been done differently: "David made a choice and acted on that choice, and we will never know if that was because the police were at the door or because he had decided, regardless of the presence of the police, to take his own life. ....What we do know is that the police were acting completely properly according to the police training."

22 Counsel for the involved officers and the Hamilton Police Service equally argued to the jury that no recommendations were required.

23 Inquest counsel reminded the jury that not all cases require recommendations. Inquest Counsel also suggested to the jury that the evidence demonstrated that policies, training and other supports provided to the officers to address the situation that unfolded on November 3, 2019, were adequate and there were no gaps that required recommendations from this inquest jury.

CLOSING COMMENT

24 In closing, I would like to again express my condolences to the family and friends of David Thomson for their profound loss. His son, who was 10 years of age at the time, may at a time of his choosing, seek to find out more about the circumstances that led to his father's death. Hopefully this verdict explanation will provide him those answers.

25 I would like to thank the witnesses and parties to the inquest for their thoughtful participation, and to thank the inquest counsel, investigator, and constable for their hard work and expertise. I would also like to thank the members of the jury for their commitment to the inquest.

26 One purpose of an inquest is to shed light on the circumstances of the death to assist the public in understanding what occurred.

27 I hope that this verdict explanation helps interested parties understand the context for the jury's verdict.

Appendix — STATEMENT OF SCOPE

Inquest into the Death of David THOMSON

This inquest will look into the circumstances of the death of David Thomson and examine the events of his death to assist the jury in answering the five mandatory questions set out in s. 31(1) of the *Coroners Act*.

(a) who the deceased was;

(b) how the deceased came to his or her death;

(c) when the deceased came to his or her death;

(d) where the deceased came to his or her death; and

(e) by what means the deceased came to his or her death

Specifically, beyond the facts required to accurately answer the five questions and understand the circumstances of the death, we will be addressing the following issues to the extent that these issues may have relevance to potential recommendations:

1. The circumstances surrounding the death of Mr. David Thomson;

2. Police training concerning interaction with and apprehension of a high risk and/or potentially armed person who is sheltered within a locked or not immediately accessible structure;

3. The ability of police to coordinate with a hotel within which someone is sheltered to allow for communication with that person, including whether phone contact can be made through the hotel.

Excluded from the scope will be any in-depth exploration of the following:

1. Emergency or first-aid response provided to Mr. Thomson after the self-inflicted gunshot;

2. The SIU investigation into the shooting;

3. A hotel's liability for allowing dangerous/armed persons to stay in the hotel, or possible protocols for preventing such persons from staying in the hotel;

4. Any particular hotel's policies with respect to coordinating with police when there is a high risk or potentially armed person within that hotel;

5. Whether any mental heath issues or substance / opioid abuse played any role in this case. However, Mr. Thomson's state of mind at the time of the incident with police may be explored.

End of Document