

# 2019 Special Investigations Unit cases with no inquests

Learn about Special Investigations Unit cases where the Office of the Chief Coroner is not conducting an inquest, a synopsis of the case and the reasons why an inquest is unnecessary.

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## Overview

In accordance with section 18(2) of the *Coroners Act* (<https://www.ontario.ca/laws/statute/90c37?search=coroners+act#BK27>), the Office of the Chief Coroner (<https://www.ontario.ca/page/office-chief-coroner-and-ontario-forensic-pathology-service>) posts an explanation when a coroner decides not to hold an inquest into a death that was investigated by the Ontario Special Investigations Unit. The requirements for these explanations are set out in Ontario Regulation 524/18: *Publication of Chief Coroner's Explanation of the Determination Not to Hold an Inquest* (<https://www.ontario.ca/laws/regulation/180524>).

Information about 2019 Special Investigations Unit cases where an inquest did not occur are posted below, including:

- case number
  - synopsis of the case
  - reasons why the coroner determined that an inquest is unnecessary
  - additional details about the case
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## Cases between January – March

Case number: SIU #19-OVD-015 (Death: 1/19/2019)

## Synopsis

An Audi collided with another vehicle, resulting in serious injuries to both drivers. Just before the collision, an officer had been engaged in a brief attempt to pursue the Audi. The Audi driver passed away a few days after the accident. The coroner concluded that the cause of death was multiple blunt impact trauma due to a motor vehicle crash and the manner of death was accident.

Read the SIU Director's Report ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=290](https://www.siu.on.ca/en/directors_report_details.php?drid=290))

## Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the SIU Director's report. The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

## Additional details

**Date and time of death<sup>[\*]</sup>:** 1/19/2019 11:20am

**Age:** 25 or older

**Gender:** Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A

**Location:** Near Municipal Road 80 and Valleyview Road, Greater Sudbury

**Responding police service:** Greater Sudbury Police Services

**Dates of Coroner's investigation:** 1/19/2019 – 04/10/2019

**Case number:** SIU #19-PCD-021 (Death: 01/30/2019)

## Synopsis

Officers were called to a residence after receiving information that a man was armed with a firearm and intended to kill himself. Over the course of several hours, various efforts were made to contact the man from outside the house, but no contact was made. When Tactical Response Unit gained entry into the garage, they found the man dead. He had shot himself. The coroner concluded that the cause of death was a gunshot wound to the head and the manner of death was suicide.

Read the [SIU Director's Report](https://www.siu.on.ca/en/directors_report_details.php?drid=288) (https://www.siu.on.ca/en/directors\_report\_details.php?drid=288)

### Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the [SIU Director's report](#). The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

### Additional details

**Date and time of death**<sup>[\*]</sup>: 01/30/2019

**Age**: 25 or older

**Gender**: Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A

**Location**: Clark Street, Clarksburg

**Responding police service**: Ontario Provincial Police

**Dates of Coroner's investigation**: 01/30/2019 – 06/15/2019

**Case number**: [SIU #19-OOD-240](#) (Death: 02/10/2019)

### Synopsis

North Bay Police Service officers dispatched after receiving a report of a vehicle being driven erratically. Before police arrived at scene, vehicle was involved in collision. Both occupants of the vehicle fled on foot with 20-year-old male driver heading towards Lake Nipissing. When police, fire and EMS arrived on scene, the man entered the lake. Despite repeated requests for him to get out of the water, he kept swimming and they lost sight of him. Ultimately drowned.

Read the SIU Director's Report. ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=791](https://www.siu.on.ca/en/directors_report_details.php?drid=791))

### Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the SIU Director's report. The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

### Additional details

**Date and time of death**<sup>[\*]</sup>: 02/10/2019

**Age**: 13-24

**Gender**: Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A

**Location**: Memorial Drive, North Bay

**Responding police service**: North Bay Police Service

**Dates of Coroner's investigation**: 02/10/2019 – 02/04/2020

## Cases between April – June

Case number: SIU #19-OCD-087 (Death: 04/28/2019)

### Synopsis

The decedent was wanted by police on two arrest warrants for breaching conditions of release, and he was also a suspect in the shooting death of a woman. Officers were following the man when he drove into a wooded area behind a gas station. The area was contained and some time later, the decision was made to arrest him. When officers got closer to him, he ran and officers gave chase. A short time later, he shot himself in the head with a handgun. The coroner concluded that the cause of death was a gun shot wound to the head and the manner of death was suicide.

Read the SIU Director's Report. ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=598](https://www.siu.on.ca/en/directors_report_details.php?drid=598))

### Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the SIU Director's report. The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

### Additional details

**Date and time of death**<sup>[\*]</sup>: 04/28/2019 10:33 a.m.

**Age**: 25 or older

**Gender**: Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A

**Location**: Franklin Boulevard, Cambridge

**Responding police service:** Waterloo Regional Police Service

**Dates of Coroner's investigation:** 04/28/2019 – 05/15/2020

**Case number:** SIU #19-OCD-095 - (Death: 05/02/2019)  
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## Synopsis

Officers attended a residence in response to domestic situation. They found a man lying on the main floor bathroom. He had stab wounds to the neck and was doused in gasoline. He was arrested. Officers applied emergency first aid, and then CPR when he stopped breathing. When paramedics and firefighters arrived, they took over care of the man. Despite their efforts, the man was pronounced dead at the scene. A woman was found on the second floor and was transported to hospital where she was pronounced dead. A boy was taken to hospital for treatment of stab wounds. The coroner concluded that the cause of the man's death was multiple sharp force injuries to the neck and the manner of death was suicide.

Read the SIU Director's Report. ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=4923](https://www.siu.on.ca/en/directors_report_details.php?drid=4923))  
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## Reasons why the coroner determined that an inquest is unnecessary

Still under consideration for a mandatory inquest.

## Additional details

**Date and time of death**<sup>[\*]</sup>: 05/02/2019

**Age:** 25 or older

**Gender:** Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A  
\*\*\*\*\*

**Location:** Quarry Edge Drive, Brampton

**Responding police service:** Peel Regional Police

**Dates of Coroner's investigation:** 05/02/2019 – 01/22/2020

**Case number:** SIU #19-PCD-097 (Death: 05/03/2019)  
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## Synopsis

Police received calls about a vehicle driving erratically on Highway 401. Officers responded and located a vehicle that had gone off the road near Kennedy Road. An officer observed a man standing on a nearby overpass. The officer attempted to communicate with him and talk him away from the edge of the bridge. However, he fell from the platform and landed on the ground below. The coroner concluded that the cause of death was blunt impact trauma due to a descent from a height and the manner of death was suicide.

Read the SIU Director's Report ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=344](https://www.siu.on.ca/en/directors_report_details.php?drid=344)) .  
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## Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the SIU Director's report. The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

## Additional details

**Date and time of death**<sup>[\*]</sup>: 05/03//2019

**Age:** 25 or older

**Gender:** Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A  
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**Location:** Highway 401 and Kennedy Road, Scarborough

**Responding police service:** Ontario Provincial Police

**Dates of Coroner's investigation:** 05/03/2019 – 05/17/2020

**Case number:** SIU #19-TCD-098 (Death: 5/4/2019)  
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## Synopsis

An individual called police to report that a man was threatening to jump from an apartment balcony. Two officers attended at the building. These same two officers were at the apartment a month prior when the man attempted to take his life. That time, officers managed to grab the man and take him to hospital. On this occasion, the officers found the man standing on the balcony railing with his hands grabbing the lower railing of the balcony above. One of the officers tried to convince the man to step down safely onto the balcony, told him he was there to help and pleaded with him not to jump. Despite this, the man jumped from the balcony railing to the ground below. The coroner concluded that the cause of death was multiple trauma due to a descent from a significant height and the manner of death was suicide.

Read the SIU Director's Report. ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=600](https://www.siu.on.ca/en/directors_report_details.php?drid=600))  
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## Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the SIU Director's report. The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

## Additional details

**Date and time of death**<sup>[\*]</sup>: 5/4/2019 12:15 p.m.

**Age:** 25 or older

**Gender:** Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A  
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**Location:** Chalkfarm Drive, Toronto

**Responding police service:** Toronto Police Service

**Dates of Coroner's investigation:** 05/04/2019 – 08/16/2019

**Case number:** SIU #19-OCD-120 (Death: 06/04/2019)  
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## Synopsis

Police received information regarding a man in distress in the area of Northfield Drive West and Highway 85. Officers located the man and began speaking with him. Shortly after, the man descended from the overpass to the highway below. The coroner concluded that the cause of death was blunt force trauma to the head due to descent from height and the manner of death was suicide.

Read the SIU Director's Report. ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=612](https://www.siu.on.ca/en/directors_report_details.php?drid=612))  
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## Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the SIU Director's report. The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

## Additional details

**Date and time of death**<sup>[\*]</sup>: 06/04/2019

**Age:** 25 or older

**Gender:** Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A  
\*\*\*\*\*

**Location:** Highway 85, Waterloo

**Responding police service:** Waterloo Regional Police Service

**Dates of Coroner's investigation:** 06/04/2019 – 01/04/2020

**Case number:** SIU #19-TVD-144 (Death: 6/22/2019)  
\*\*\*\*\*

## Synopsis

An officer attempted to stop a motor vehicle to investigate its occupants. Moments later, the motor vehicle struck another vehicle at the intersection of Scarborough Golf Club Road and Lawrence Avenue East. The driver of the vehicle that was struck was pronounced dead at the scene. The coroner concluded that the cause of death was multiple blunt force trauma due to a motor vehicle collision and the manner of death was accident.

Read the SIU Director's Report. ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=616](https://www.siu.on.ca/en/directors_report_details.php?drid=616))  
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## Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the SIU Director's report. The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

## Additional details

**Date and time of death**<sup>[\*]</sup>: 6/22/2019 7:48 p.m.

**Age:** 25 or older

**Gender:** Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A  
\*\*\*\*\*

**Location:** Lawrence Avenue East, Scarborough

**Responding police service:** Toronto Police Service

**Dates of Coroner's investigation:** 6/22/2019 – 10/20/2019

**Case number:** SIU #19-OOD-158 (Death: 06/29/2019)  
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## Synopsis

SIU report released on April 7, 2021 (no charges). On June 25, a pregnant woman was arrested by Greater Sudbury Police and “grounded” in process. Four days later, she gave birth to her child. Because of newborn’s premature birth, the baby passed away less than an hour after being born. Mother told coroner that police use of force during arrest caused her child’s death.

Read the SIU Director’s Report. ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=1203](https://www.siu.on.ca/en/directors_report_details.php?drid=1203))  
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## Reasons why the coroner determined that an inquest is unnecessary

Still under consideration for inquest.

## Additional details

**Date and time of death**<sup>[\*]</sup>: 06/29/2019

**Age:** 0–12

**Gender:** Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A  
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**Location:** Health Sciences North, Sudbury

**Responding police service:** Greater Sudbury Police Services

**Dates of Coroner's investigation:** 06/29/2019 – 04/23/2020

## Cases between July – September

**Case number:** SIU #19-OVD-161 (Death: 07/07/2019)

### Synopsis

An officer observed a vehicle of interest, a Honda, and engaged in a pursuit on Highway 417. The pursuit was ended. Shortly thereafter, the Honda moved into the on-coming lanes of the highway, accelerated, and crashed head-on into two motor vehicles, killing the female driver of one and seriously injuring the driver and passenger of another. The male driver of Honda also died as a result of the collision. The coroner concluded that the cause of death was multiple injuries due to a motor vehicle collision and the manner of death of the Honda driver was suicide.

Read the SIU Director's Report. ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=668](https://www.siu.on.ca/en/directors_report_details.php?drid=668))

### Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the SIU Director's report. The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

### Additional details

**Date and time of death**<sup>[\*]</sup>: 07/07/2019

**Age**: 25 or older

**Gender**: Male and Female

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A

**Location**: Highway 417 near Arnprior, Ottawa

**Responding police service:** Ottawa Police Service

Ontario Provincial Police

**Dates of Coroner's investigation:** 07/07/2019 – 05/15/2020

**Case number:** SIU #19-OVD-196 (Death: 08/16/2019)

## Synopsis

An officer observed a motorcycle operating at a high rate of speed. The officer turned on his emergency lighting system and made a U-turn to follow. However, for safety purposes, the officer immediately turned off his emergency lights and abandoned any possible pursuit before it even started. A short time later, the motorcycle became involved in a collision with another vehicle. The motorcyclist was pronounced dead at the scene. The coroner concluded that the cause of death was blunt trauma to the head and torso due to a motor vehicle collision and the manner of death was accident.

Read the SIU Director's Report. ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=693](https://www.siu.on.ca/en/directors_report_details.php?drid=693))

## Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the SIU Director's report. The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

## Additional details

**Date and time of death**<sup>[\*]</sup>: 08/16/2019

**Age:** 25 or older

**Gender:** Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A

**Location:** Woodlawn Road, Welland

**Responding police service:** Niagara Regional Police Service

**Dates of Coroner's investigation:** 08/16/2019 – 01/22/2020

**Case number:** SIU#19-OCD-206 (Death: 8/25/2019)  
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## Synopsis

Police were dispatched to a residence in response to a domestic situation. Before police arrived, a man left the residence. With the help of the canine unit, officers located the man in the backyard of a residence on a nearby street. While in police presence, the man sustained a fatal, self-inflicted gunshot wound. No officer discharged a firearm. The coroner concluded that the cause of death was a gunshot wound to the head and the manner of death was suicide.

Read the SIU Director's Report. ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=783](https://www.siu.on.ca/en/directors_report_details.php?drid=783))  
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## Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the SIU Director's report. The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

## Additional details

**Date and time of death**<sup>[\*]</sup>: 08/25/2019 1:33 a.m.

**Age:** 25 or older

**Gender:** Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A  
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**Location:** Ogden Avenue, Mississauga

**Responding police service:** Peel Regional Police

**Dates of Coroner's investigation:** 08/25/2019 – 12/05/2019

**Case number:** SIU #19-OCD-213 (Death: 09/06/2019)  
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## Synopsis

A man descended to his death off the Derry Road overpass onto the southbound lanes of Hwy 410. Seconds prior to his death, two officers had arrived on the overpass to render assistance to the man. The coroner concluded that the cause of death was multiple blunt force injuries and the manner of death was suicide.

Read the SIU Director's Report. ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=731](https://www.siu.on.ca/en/directors_report_details.php?drid=731))  
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## Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the SIU Director's report. The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

## Additional details

**Date and time of death**<sup>[\*]</sup>: 09/06/2019

**Age:** 25 or older

**Gender:** Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A  
\*\*\*\*\*

**Location:** Derry Road, Mississauga

**Responding police service:** Peel Regional Police

**Dates of Coroner's investigation:** 09/06/2019 – 04/26/2020

**Case number:** SIU #19-PVD-229 (Death: 9/17/2019)  
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## Synopsis

At approximately 11:40 p.m. on September 16, 2019, an Ontario Provincial Police officer was operating a police vehicle in the New Tecumseth area when he observed a Pontiac. The officer began to follow this vehicle. In the area of 20th Sideroad and 5th Line, the Pontiac became involved in a collision with a Volkswagen. Two women from the Volkswagen – the 23-year-old driver and 36-year-old passenger – were taken to hospital for treatment. The passenger was later pronounced dead in hospital. A woman passenger from the Pontiac was also taken to hospital for treatment of injuries.

Read the SIU Director's Report. ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=695](https://www.siu.on.ca/en/directors_report_details.php?drid=695))  
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## Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the SIU Director's report. The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

## Additional details

**Date and time of death**<sup>[\*]</sup>: 9/17/2019 1:45 a.m.

**Age:** 25 or older

**Gender:** Female

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A  
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**Location:** Southlake Hospital, Newmarket

**Responding police service:** Ontario Provincial Police

**Dates of Coroner's investigation:** 9/17/2019 – 05/18/2020

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## Cases between October – December

**Case number:** SIU #19-POD-275 (Death: 11/19/2019)

### Synopsis

Lac Seul Police officers and Ontario Provincial Police (OPP) officers responded to a residence after receiving a call about a man who had barricaded himself. Police set up a perimeter and made attempts to contact the man. The next morning, the OPP Tactical Response Unit took control of the scene. Attempts to contact the man continued. Concerned for the man's well-being, officers entered the residence. Soon after, the man died of a self-inflicted gunshot wound. The coroner concluded that the cause of death was a gunshot wound to the head and neck and the manner of death was suicide.

Read the SIU Director's Report. ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=751](https://www.siu.on.ca/en/directors_report_details.php?drid=751))

### Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the SIU Director's report. The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

### Additional details

**Date and time of death**<sup>[\*]</sup>: 11/19/2019

**Age:** 25 or older

**Gender:** Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A  
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**Location:** Kejick Bay, Lac Seul First Nation

**Responding police service:** Lac Seul Police and Ontario Provincial Police

**Dates of Coroner's investigation:** 11/19/2019 – 08/10/2020

**Case number:** SIU #19-OVD-314 (Death: 12/31/2019)  
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## Synopsis

An officer was on patrol when she observed a vehicle travelling at high rate of speed. The officer followed the vehicle with the intention of stopping it. When the officer lost sight of the vehicle, she turned off her lights and siren, slowed down and disengaged. The vehicle of interest collided with a third vehicle. The driver of the third vehicle was pronounced dead at the scene. The coroner concluded that the cause of death was blunt neck trauma due to a motor vehicle collision and the manner of death was accidental.

Read the SIU Director's Report. ([https://www.siu.on.ca/en/directors\\_report\\_details.php?drid=779](https://www.siu.on.ca/en/directors_report_details.php?drid=779))  
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## Reasons why the coroner determined that an inquest is unnecessary

The matters described in sections 31(1)(a) to (e) of the *Coroners Act* are known. The circumstances surrounding the death have been investigated and disclosed to the public in the SIU Director's report. The actions of the involved police service members did not materially contribute to the death. The circumstances of the death do not give rise to significant systemic issues that would likely result in preventative recommendations.

## Additional details

**Date and time of death**<sup>[\*]</sup>: 12/31/2019

**Age:** 25 or older

**Gender:** Male

**Race** (if provided to the Coroner by a family member)<sup>[\*\*]</sup>: N/A  
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**Location:** 9th Line, Markham

**Responding police service:** York Police Service

**Dates of Coroner's investigation:** 12/31/2019 – 06/01/2010

## Related

Death investigations (<https://www.ontario.ca/page/death-investigations>)

Office of the Chief Coroner and Ontario Forensic Pathology Service  
(<https://www.ontario.ca/page/office-chief-coroner-and-ontario-forensic-pathology-service>)

Coroner's inquests (<https://www.ontario.ca/page/coroners-inquests>)

Status of [SIU](https://www.siu.on.ca/en/case_status.php) cases ([https://www.siu.on.ca/en/case\\_status.php](https://www.siu.on.ca/en/case_status.php))  
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## Contact

### Phone numbers and email

Tel: 416-314-4000  
\*\*\*\*\*

Toll-free: 1-877-991-9959 (Ontario only)  
(Monday to Friday 8:30 a.m. to 5:00 p.m. except statutory holidays)

TTY: 416-326-5511  
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Toll-free TTY: 1-866-517-0572  
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 [inquiries@ontario.ca](mailto:inquiries@ontario.ca) (<mailto:OCC.inquiries@ontario.ca>)

## Address

SIU  
\*\*\*\*\*

25 Grosvenor Street, 15<sup>th</sup> Floor  
Toronto, Ontario  
M74 1Y6

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## Footnotes

- [\*] ^ The time of death is not routinely documented by investigating coroners as pronouncement of death is a variable process depending on circumstances. Time of death will be posted if documented.
- [\*\*] ^ Race has not been routinely collected by investigating coroners, however an updated case information system in the process of implementation will include this data in the majority of cases.