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STATEMENT ON BEHALF OF YANG YU AND HIS FAMILY

September 17, 2026

On May 4, 2026, Heiniu — a healthy two-year-old Rottweiler who was a beloved member of the Yang family— died in a neighbour's driveway in Holland Landing while restrained by two municipal animal services officers using two catch poles. Neighbours had already caught and leashed him on their private property. The containment was reported to Animal Services at 4:20 p.m. The first officer arrived at 4:56 p.m.

On September 15, 2026, the Town of Aurora released a 362-page report prepared by Canine Foundations Inc., submitted to the Town on August 21, 2026. Mr. Yu and his family have now read it, and I have reviewed it on their behalf.

This statement sets out what the report establishes, what it leaves unanswered, and what the family is asking for in the circumstances. Every finding attributed to the report below appears in that document.

The family's concern is with accountability for the decisions, training, supervision, policies and oversight that produced this avoidable outcome. They ask that the individual officers not be named publicly and not be subjected to abuse. Nothing in this statement should be read as expressing a view about any person's legal responsibility, and the family reserves all of its rights.

1. THE REPORT CONTRADICTS WHAT THE PUBLIC WAS TOLD

In its public statement of May 12, 2026, the Town described two dogs at large, an officer sustaining a bite injury requiring medical attention, escalating safety concerns, the presence of bystanders, and staff working to safely calm, care for and secure Heiniu.

The Town's own consultant found otherwise.

- The dogs had already been contained by residents on private property before any officer arrived.
- Heiniu did not display generalized or indiscriminate aggression at any point. His communication was expressed through resistance, posture and stillness rather than barking, growling or lunging.



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- The bite occurred within an identifiable behavioural sequence, immediately following direct collar contact, and is most consistent with a context-dependent defensive response. It was not a sustained or offensive attack.
- The “bystanders” were residents the officers themselves relied on to handle and restrain Heiniu— including after the officer had decided she was not comfortable managing him alone, and after she had requested police assistance. The report found no divisional procedure addressing when members of the public should be involved in an animal control incident, or when their involvement should stop.
- Two full-time officers were covering three municipalities that day. The supervisor was on scheduled leave and gave guidance remotely. No mutual aid framework existed.
- York Regional Police were contacted by a member of the public at the officers’ direction, not by the officers themselves. No service agreement or inter-agency protocol with York Regional Police was identified.

2. THE REPORT FINDS THE ESCAPE FROM THE VEHICLE WAS A PROCEDURAL FAILURE

This has not been reported, and it matters, because everything that followed flowed from it.

The report records that the first officer rushed through her own checklist and did not read the shelter’s email — which contained the owners’ information — before leaving her vehicle. She approached without the camera and scanner her own procedure required. She did not greet either dog before handling them. When she placed a slip lead over Heiniu’s head she saw his eyes widen and recognised an emotional shift, but, in the report’s words, could not understand what that shift indicated, and did not factor it into what she did next.

Heiniu was then loaded into the vehicle without difficulty. Since the officer had not followed the photograph procedure, she had to open the kennel door a second time to take the photograph — and the report states in terms that this is what allowed Heiniu to escape the enclosure.

The report also records why Heiniu was being loaded at all. The officer had given the finder a witness statement to complete on the basis that the dog had been running at large, and wished to proceed with a review into the owner. That, the report says, is what drove the decision to load

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the dogs, and what drove the repeated attempts to reload Heiniu after he got out — despite the officer having the owners' contact information already in her possession.

3. WHAT THEN HAPPENED TO HEINIU

The report's own corroborated timeline, drawn from the Town's records, telephone logs, doorbell camera footage and timestamped photographs, establishes the following.

- At approximately 5:45 p.m. the officer was bitten, immediately after reaching for Heiniu's collar. She dropped the leash and returned to her vehicle, roughly 160 feet down the private driveway, where she made a telephone call at 5:49 p.m. A member of the public held the dog until the catch poles were brought.
- Two catch poles were then applied. The second was applied shortly after the first, with no attempt to move or load Heiniu in between such that there was no opportunity to assess whether one pole was sufficient.
- By 5:58 p.m., video records substantial visible blood. No visible blood was reported by anyone present before the two catch poles were applied.
- A timestamped photograph between 6:11 and 6:20 p.m. shows Heiniu lying on the ground with both poles still applied.
- Heiniu was not released from the catch poles until approximately 7:03 p.m. By then, Heiniu had fallen onto his side and become unresponsive, a toe-pinch assessment had produced no response, and his family had arrived.

Heiniu was visibly bleeding, under dual restraint, for roughly an hour.

4. THE REPORT'S FINDINGS ON THE HANDLING

Both officers had completed training in the use of catch poles. The report identifies how their handling of Heiniu departed from it:

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- Neither officer used the two-point check system taught in their catch-pole training, which exists precisely to avoid the repeated tightening and loosening of the cables that two independent witnesses described and both officers acknowledged.
- Hand positioning provided fewer effective points of control than the training demonstrated.
- The poles were transferred between officers, leaving one officer controlling both at times, which the report finds was inconsistent with the training.
- The poles were used to lift Heiniu off the ground during loading, with the lifting force applied through the restraint around his neck. One officer described her pole approaching shoulder height. Catch poles are not designed to lift an animal, and the report finds this was a departure from their intended function and from recognized handling guidance.
- No purpose-designed muzzle was used. An attempt was made to fashion one from a slip lead.
- No loading plan had been established before dual restraint was applied. Once both officers were committed to poles and the civilian had been stood down on safety grounds, nobody remained to support the dog's hindquarters, which is why the poles were used to lift him.
- The report identifies no structured reassessment of his physical condition at any point during dual restraint, despite episodes of violent thrashing, periods of stillness, and visible blood at Heiniu's mouth and nose.
- After Heiniu collapsed, the report records no evidence that his breathing or pulse was ever assessed.

The report concludes that key safety elements of the officers' training were not applied during portions of the incident, that the response did not adapt as circumstances changed, which it calls one of its most consistently supported findings, and that restraint-related injury cannot be excluded as a contributing factor to the death.

5. WHAT THE REPORT DOES NOT DO

The Yang family were never interviewed. The review interviewed both responding officers twice each, management, three independent civilian witnesses and an enforcement witness.



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Interviews with the owners were treated as outside the scope of the engagement. The only participants excluded were the family whose dog had died.

The report does not determine how Heiniu died. It attributes that gap to a veterinary necropsy not having been provided to the reviewer.

That account is incomplete, and the family has asked the Town to correct it.

A necropsy was performed at the Animal Health Laboratory at the University of Guelph by a board-certified veterinary pathologist and finalised on June 22, 2026.

On June 24, 2026, at the request of the provincial Animal Welfare Services investigator, Mr. Yu provided it to her, together with his written answers to her questions, photographs, video, a veterinary record and statements from independent eyewitnesses. She confirmed the same day that the province's veterinarian saw no need for further testing.

Mr. Yu cooperated fully with the independent statutory authority. What he declined was to hand his private veterinary records to a consultant retained and paid by the Town, at a time when the Town had refused to produce the retainer agreement, refused to state the scope of the consultant's mandate, refused to answer questions about a review team member's employment with a municipal animal services department in a neighbouring jurisdiction — and had confirmed in writing, on July 13, 2026, that it was relying on no authority in asking for the materials.

In that same letter, the Town told Mr. Yu's counsel what the report would say if the records were not provided: that Canine Foundations would simply note that they had been requested but not provided. That is what the report says, and it is the stated basis for its inability to determine the cause of death.

6. A QUESTION ABOUT THE SCOPE OF THE REVIEW

The contract between the Town and Canine Foundations, as disclosed to the family, states that the work would be focused solely on the Town's policies and procedures for animal handling, that it would not be a parallel investigation, and that it would not provide any opinion on other matters related to the animal's death, including animal welfare or employment-related matters.



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The report that was delivered contains a multi-phase behavioural analysis of Heiniu, an assessment of whether restraint contributed to his death, and findings about two employees' training compliance, communication and record-keeping. Its appendix of qualifications is headed "Investigator Qualifications."

Either the mandate was exceeded, or it was changed by an instrument the Town has not disclosed. The family has asked the Town to explain which, and that request remains outstanding.

7. WHAT THE FAMILY IS ASKING FOR

- The Town correct the report's account of Mr. Yu's conduct, and publish that correction alongside the report. A formal request under the privacy legislation was delivered on September 16, 2026.
- The Town release the underlying evidence. The report's own appendix lists roughly seventy records it relied on — interview recordings and transcripts, dispatch and CRM records, telephone logs, officers' notes, doorbell and witness video, training records and an incident timeline. None of it has been released.
- The Town account for the difference between the mandate it described and the report it received.
- The provincial Animal Welfare Services investigation be allowed to run its course. It is the genuinely arm's-length process here, and the family has cooperated with it fully.

Mr. Yu has seven access requests outstanding with the Town of Aurora, six appeals before the Information and Privacy Commissioner, and further appeals in preparation. A complaint to the Ontario Ombudsman is under consideration.

8. THE FAMILY'S POSITION

The report makes twelve recommendations. The first is that the Town develop a critical incident response protocol for incidents involving serious injury or death, covering scene preservation

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and evidence collection. That such a protocol did not exist, and that the Town's own consultant found its post-incident response fell short of accepted practice, is itself part of the answer to why this family still has no answers.

Implementing the recommendations is necessary. It is not sufficient. Recommendations are about the next incident. They do not explain this one, they do not answer the question this family has asked since May, and they are not accountability.

Heiniu was corralled, leashed, safe, and calm in a neighbour's yard by 4:20 p.m. By 7:00 p.m. he was dead. His family has never been told why.

TIMELINE — MAY 4, 2026 *(times as recorded in the Town's report)*

4:20 p.m.	Two dogs reported contained by residents on private property, having reportedly been at large during the day.
4:56 p.m.	The first officer arrives — thirty-six minutes after the containment was reported.
Shortly after	The German Shorthaired Pointer is photographed, scanned and loaded without difficulty. Heiniu is loaded without reported difficulty. The officer opens the kennel door a second time to take a photograph she had not taken. Heiniu exits the vehicle.
Approx. 5:45 p.m.	A second officer has attended. She reaches for Heiniu's collar and is bitten. The first officer drops the leash and returns to her vehicle, approximately 160 feet down the driveway.
5:49 p.m.	Telephone contact recorded. Two catch poles are retrieved and applied.
5:58 p.m.	Video records substantial visible blood. No visible blood was reported before the poles were applied.
6:11–6:20 p.m.	A timestamped photograph shows Heiniu lying on the ground with both catch poles applied.



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Shortly before 7:00 p.m.	Heiniu lies down, his chest rises a few times, he falls onto his side and becomes unresponsive. A toe-pinch assessment produces no response.
7:00 p.m.	Heiniu's family arrives on scene.
Approx. 7:03 p.m.	The catch poles are loosened and removed.
7:18 p.m.	Officers clear the scene.
7:36 p.m.	They arrive at the emergency veterinary clinic with Heiniu.

**The full Canine Foundations report is published on the Town of Aurora's website.*
