CONFIDENTIAL

Report to:

OTTAWA POLICE SERVICE BOARD COMPLAINTS COMMITTEE

31 March 2026

Submitted by: Executive Director, Ottawa Police Services Board

Contact Person:

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SUBJECT: REVIEW OF COMPLAINT INV-25-183

REPORT RECOMMENDATIONS:

That the Ottawa Police Service Board's Complaints Committee:

1. **Review Policy and Procedure Complaint No. INV-25-183 pursuant to section 107(7) of the *Community Safety and Policing Act, 2019*.**
2. **Recommend that the Board's Policy and Governance Committee review Board Policy LE-037 Sudden Death and Found Human Remains to explicitly require the Chief to establish procedures that assign responsibility for coroner notification to a named role in field response to unexpected deaths.**
3. **Recommend that the Chief take into consideration the findings of this review in the ongoing revision of Chief's Procedure 11.25.**
4. **Authorize the Executive Director to communicate the Committee's findings to the Inspector General, the Solicitor General, and the complainant.**
5. **Authorize the Executive Director to publish this report (without supporting documents) on the Board's website for the purpose of informing the public of the Board's findings and the actions recommended in response to this complaint.**

BACKGROUND

Policy and Procedure Complaints are complaints referred to the Board by the Inspector General of Policing pursuant to subsection 107(6) of the *Community Safety and Policing Act, 2019* (CSPA). Under subsection 107(1) of the CSPA, the Inspector General is responsible for receiving and addressing complaints relating to policing, including complaints concerning the policies, by-laws, rules, or procedures of a police service

board and the procedures established by a chief of police. Where the Inspector General determines that such a complaint is appropriately addressed at the governance level, subsection 107(6) requires the Inspector General to refer the complaint to the relevant police service board and to inform the complainant of that decision.

Upon referral, the Board is required under subsection 107(7) of the CSPA to review the complaint as it relates to Board policies and Chief's procedures, and to report back to the Inspector General and to the Solicitor General on any steps taken. The Inspector General has generally specified a 90-day timeline for the completion of such reviews.

The Board's Policy CR-32 Policy and Procedure Complaints establishes the framework for administering these reviews. Under that policy, upon receipt of a referral the Executive Director notifies the Chief, gathers relevant Chief's Procedures and contextual information, conducts a review of applicable Board policies, and prepares a comprehensive report addressing the complaint as it relates to both Board policies and Chief's procedures. The Executive Director then submits that report to the Complaints Committee.

The Complaints Committee's role is to conduct an action-oriented review of the complaint and to identify opportunities for corrective action or improvement. In exercising its delegated authority, the Committee may request additional information, approve the Board's response to the Inspector General, endorse or modify recommendations contained in the report, and identify broader governance or policy issues for consideration by the Board or its committees. The review does not extend to findings regarding the conduct of individual members of the Ottawa Police Service.

Following the Committee's review, the Executive Director communicates the outcome to the Inspector General, the Solicitor General, and the complainant, subject to any limitations or conditions determined by the Committee.

DISCUSSION

Summary of the complaint

The complaint arises from the unexpected death of the complainant’s father, at a retirement home in Ottawa on March 31, 2025. The complainant alleges that Ottawa Police Service (OPS) officers attended the scene but failed to notify the coroner as required, that their father lay in his room for more than twelve hours before the coroner attended, and that OPS may lack adequate policies, training, and oversight to ensure compliance with coroner notification requirements in unexpected death cases.

Steps taken in response to the complaint

Upon receipt of the Inspector General's referral on December 5, 2025, a review of this complaint was commenced, focused strictly on Board policies and procedures established by the Chief of Police. This review does not examine the facts of the incident beyond the information provided by the Inspector General, nor does it assess the conduct of any OPS member. The review is confined to assessing whether any clarification or updates to policies or procedures are warranted.

To inform this review, the Board office requested the assistance of the OPS Professional Standards Unit (PSU). The following materials were provided by the PSU: Chief's Procedure 11.25 (Sudden Death/Found Human Remains), effective January 23, 2017; and the OPS Computer-Aided Dispatch (CAD) log for the call associated with the incident described in the complaint. These materials were reviewed alongside the complaint documentation attached to the Inspector General's referral and the relevant provisions of the Coroners Act.

Review of the complaint as it pertains to board policies or procedures

The CAD log discloses the following sequence. OPS received the call at 8:25 a.m. and officers arrived on scene approximately five minutes later. The initial call remarks note that the deceased had a Do Not Resuscitate order on file. The attending officer confirmed the death, assessed it as non-suspicious, and cleared the scene at 9:38 a.m. with the notation: "CORONER INFORMATION PROVIDED TO RETIREMENT HOME." At 5:12 p.m., nearly nine hours after officers first attended the scene, the retirement home called OPS again to report that the coroner had still not attended. A second police unit was dispatched. The final clear remark, entered at 5:31 p.m., reads: "FROM OAC, HOME STAFF FORGOT HOW TO CALL CORONER, INFO WAS PASSED ON TO THE HOME, OPS NOT REQUIRED."

The relevant legal framework is contained in the *Coroners Act, 1990*. Section 10(1) of that Act establishes a mandatory notification chain: any person with reason to believe that a death has occurred in circumstances that may require investigation must immediately notify a coroner or a police officer; and where a police officer is so notified, that officer is required to in turn immediately notify the coroner. The obligation to report the death to the coroner is transferred to the officer at the moment of notification. The officer's statutory duty to notify the coroner is not delegable. The Act does not permit an officer to discharge it by providing the coroner's contact information to a third party.

The review considered whether section 10(2.1) of the Coroners Act is separately engaged. That provision imposes a direct and independent notification obligation on the person in charge of a long-term care home to which the Fixing Long-Term Care Act, 2021 applies. The available record indicates that the death occurred at a retirement

home regulated under the *Retirement Homes Act, 2010* and subject to the oversight of the Retirement Homes Regulatory Authority, not a long-term care home within the meaning of the *Fixing Long-Term Care Act*. Section 10(2.1) accordingly does not apply to this incident.

The review also considered the exceptions set out in section 10(2), which place the duty to notify on the person in charge of a hospital, institution, or residents' home. None of these exceptions apply to the death of residents of retirement homes.

Consequently, the retirement home's staff bore no independent statutory obligation to notify the coroner. Once OPS was on scene and had confirmed the death, the section 10(1) obligation was OPS's alone to discharge.

Chief's Procedure 11.25 *Sudden Death/Found Human Remains* implements this statutory framework. General Procedure section 4 states without qualification: "The coroner shall be contacted by the Service in **all** deaths" (emphasis added). The obligation is categorical and exceeds the requirements of the *Coroners Act* which, as noted above, includes exceptions to the police officer's duty to notify the coroner.

Procedure 11.25 defines "Expected Death" narrowly – a patient under active palliative care for a terminal illness, receiving constant medical supervision from a recognized nursing agency – and expressly states that the fact that a person is sick or elderly does not mean a death is expected. Although the Procedure requires the Service to notify the coroner of all deaths – which is understood to include Expected Deaths – the presence of this narrow definition, in conjunction with the provisions of the *Coroners Act*, should leave no doubt as to whether the duty to report a death in the circumstances rested on the police officer or the person in charge of the facility.

The presence of a Do Not Resuscitate order is a resuscitation directive for EMS purposes and does not qualify or displace the coroner notification obligation in section 4 of the Procedure.

However, the Board's review of the complete Procedure 11.25 identifies a potential gap. By stating that the Service shall contact the coroner in all deaths, the Procedure establishes an institutional obligation, but the Procedure, including its Roles and Responsibilities section, does not clearly assign the coroner notification obligation to any specific role in a field response to an unexpected death. The Police Officers section lists the attending officer's obligations – submit a report, secure the premises, notify next of kin – but does not include contacting the coroner. The Frontline Supervisor at the Scene section is similarly silent. The Communications Centre section assigns a coroner notification function only where police are *not* attending (section A.1(b)). Once

police are dispatched and on scene, Communications has no coroner notification role either. The only role in the entire procedure explicitly directed to "contact the coroner" is the Cell Block Supervisor, in the distinct context of a death in custody.

The fact that the Procedure does not assign individual responsibility for the notification is mitigated by the fact that the *Coroners Act* should leave little doubt as to who carries the duty to notify. Indeed, section 10(1) of the Act reads: "where a police officer is notified he or she shall in turn immediately notify the coroner" of the facts and circumstances of the death. The duty to notify the coroner would indeed rest on the attending officer who would have collected an account of the facts and circumstances of the death from the person in charge.

The attending officer's clearance notation – "CORONER INFORMATION PROVIDED TO RETIREMENT HOME" – seems to reflect a treatment of the notification obligation as delegable to the retirement home's staff. Under section 10 of the *Coroners Act*, that obligation was OPS's to discharge. Under section 4 of Procedure 11.25, the coroner was to be contacted by the Service. Neither obligation seems to have been met. The retirement home's staff bore no independent statutory duty under section 10(2) or 10(2.1) that could have served as a substitute. And the gap in the Roles and Responsibilities section of the Procedure may have meant that no officer was explicitly directed to make the call. The result, reflected in the CAD log, was a nine-hour interval between OPS first attending the scene and the eventual coroner notification.

This report does not make any finding about whether individual officers complied with their legal duties under the Coroners Act or any other legislation. That assessment is beyond the scope of this review. The findings are confined to the procedure itself. While the institutional obligation was clear, its operationalization at the role level may have been unclear. That gap may be remedied in the revision of Procedure 11.25 currently underway.

The review also considered Board Policy LE-037 Sudden Death and Found Human Remains. LE-037 directs the Chief to develop and maintain procedures for sudden or unexplained death investigations but does not specifically address coroner notification obligations and does not reference the Coroners Act. It is therefore recommended that Policy LE-037 be amended to address the need for clear roles and responsibilities in notifying the coroner of unexpected deaths.

CONSULTATION

N/A

FINANCIAL IMPLICATIONS

N/A

SUPPORTING DOCUMENTATION

Document 1: Inspector General Referral Letter to Chair Fakirani, INV-25-183 (December 5, 2025)

Document 2: Inspector General Letter to Complainant re INV-25-183 (December 5, 2025)

Document 3: LECA Forwarding Letter to Inspector General (November 4, 2025)

Document 4: Complaint Form CO-0012675

Document 5: Chief's Procedure 11.25, Sudden Death/Found Human Remains (effective January 23, 2017, marked Under Review)

Document 6: OPS Computer-Aided Dispatch Log, Call 25-80361 (March 31, 2025)

CONCLUSION

The experience described in this complaint warrants acknowledgment. Losing a parent is among the most difficult experiences a person can face. When the circumstances surrounding that loss raise questions about whether mandatory legal obligations were met, the grief is compounded by uncertainty and, in this case, by an extended wait that should not have occurred. The complainant’s decision to bring this matter forward has served a constructive purpose: it has surfaced a procedural gap that, if addressed, will reduce the likelihood of a similar experience for another family.