

**CONFIDENTIAL**

**Report to:**

**OTTAWA POLICE SERVICE BOARD COMPLAINTS COMMITTEE**

**7 May 2026**

**Submitted by: Executive Director, Ottawa Police Service Board**

**Contact Person:**

**Habib Sayah, Executive Director, Ottawa Police Service Board**

***habib.sayah@ottawa.ca***

**SUBJECT: REVIEW OF COMPLAINT INV-25-189**

**REPORT RECOMMENDATIONS:**

**That the Ottawa Police Service Board's Complaints Committee:**

- 1. Review Policy and Procedure Complaint No. INV-25-189 pursuant to section 107(7) of the *Community Safety and Policing Act, 2019*.**
- 2. Recommend that the Board's Policy and Governance Committee undertake a substantive review of Board Policy LE-013 in consultation with the Ottawa Police Service's Mental Health Advisory Council (MHAC), with a view to producing a revised policy that articulates the values and outcomes the Board expects to be achieved in OPS interactions with individuals with special needs or those experiencing mental health challenges, reflects current community expectations and best practices as required by Ontario Regulation 392/23.**
- 3. Recommend that the Chief, in coordination with the Policy and Governance Committee's review of Board Policy LE-013 and through the same consultation process with MHAC, establish written procedures governing OPS response to incidents involving individuals with special needs.**
- 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 complainant describes that on the morning of September 18, 2025, at approximately 12:30 a.m., three OPS officers attended his family's residence and

knocked on the door. The complainant was away at work while his wife and two sons were at home. The stated reason for the visit was to follow up on a community concern involving the complainant's son, a 33-year-old man with a developmental disability, who had on the previous day and again that afternoon approached a 14-year-old girl getting off a school bus in the neighbourhood, hugged her, and asked her to jump on his back. The girl's parent, who placed the call to OPS, described the contact as unwanted and alarming. The complainant does not dispute that girl's parent made the right decision in contacting police, and nor does not take issue with the notion that an OPS response was warranted. The complaint is directed specifically at the timing and manner of that response: three officers arriving unannounced at 12:30 a.m. in relation to a matter that was non-criminal and that, in his submission, could and should have been addressed during reasonable hours, especially in light of the subject being an individual with special needs. The complainant describes the late-night visit as grossly unprofessional and traumatizing.

The Inspector General classified this complaint as relating to Board policies and Chief's procedures governing the response to individuals with special needs and the conduct of residential visits.

### **Steps taken in response to the complaint**

Upon receipt of the Inspector General's referral on December 17, 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:

- the OPS Call Response Protocol (issued June 9, 2021);
- the Computer-Aided Dispatch (CAD) log for the call associated with the incident described in the complaint; and
- a January 5, 2026 communication from the Chief of Police to all members regarding updated notification practices for Priority 3 and 4 calls.

The PSU confirmed that no Chief's procedure specifically governing OPS response to individuals with developmental disabilities in non-criminal matters was identified.

These materials were reviewed alongside the complaint documentation attached to the Inspector General's referral.

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

#### CAD Log

The CAD log describes the following sequence.

OPS received the call on the afternoon of September 17, 2025, at approximately 4:15 p.m. The caller was the mother of a 14-year-old girl who lived in the same neighbourhood as the subject. The initial remarks recorded at the time of receipt described a developmentally delayed man who had, on the previous day and again that afternoon, followed the girl as she got off her school bus, hugged her, told her to hug him tighter, and asked her to jump on his back. The call was initially classified as a disturbance requiring mobile response and carried a Priority 4 designation. The Divisional Staff Sergeant was notified of the unserved call at 6:29 p.m. and again at 8:33 p.m.. Officers were not dispatched until 11:44 p.m. and arrived on scene shortly after midnight – an interval of more than seven and a half hours from receipt to dispatch. When officers arrived, they attended first to the girl and her parents, whose account was consistent with what had been recorded at the time the call was received. The girl confirmed she had felt uncomfortable but made no allegations of a criminal offence. Officers then attended the subject's residence and spoke with his mother, who confirmed that her son functions at the level of a ten-year-old. She undertook to restrict his movements to their street going forward. The call was cleared at 1:05 a.m.

#### Call Response Protocol

The Call Response Protocol, issued June 9, 2021, governs how calls for service are prioritized and dispatched. Priority 4 calls are defined as "all other incidents that require a mobile response," and carry a response time goal of 120 minutes, 90% of the time. The interval between receipt and dispatch in this case was more than three times the stated goal.

The Protocol contains two provisions directly relevant to this outcome. Section D.1(c) requires that where the 120-minute response goal is not met, the shift manager or supervisor will ensure that the complainant is contacted and advised of the delay. General Provision 1 requires any member who receives information warranting a re-evaluation of the assigned priority to contact the Communications Centre to modify the call's priority. The CAD log indicates the Divisional Staff Sergeant was notified twice while the call remained unserved. The record does not indicate that a re-evaluation of the Priority 4 classification was conducted, notwithstanding that the underlying

circumstances – an adult male repeatedly approaching a young person at a bus stop – may have warranted reconsideration.

### Response Time

The response time – understood as the interval between the call for service is received and officers arrive on scene – in this case warrants brief comment. The interval of more than seven and a half hours between receipt and on-scene significantly exceeded the 120-minute Priority 4 goal established by the Call Response Protocol, and that failure was a contributing factor to the timing of attendance.

The Board's Strategic Plan 2024-2027 identifies Priority 1 through 4 response times as key performance indicators under Objective 1.4, Improve Organizational Efficiency, within Pillar 1, Enhanced Community Safety. While a target response time for Priority 1 calls has been formalized, targets for Priority 2 through 4 calls are identified as under review for the purpose of developing operationally feasible benchmarks. Response times are not currently addressed at the Board policy level as a standalone matter, and this review does not recommend that they be. Response times are contingent on staffing levels and resource allocation and are more appropriately addressed through the annual police budget process and through the development of updated targets already contemplated by the Strategic Plan.

The response time in this case contributed materially to the circumstances that gave rise to the complaint, but it is not the central governance concern the complaint raises. The more significant issue – the one this review addresses – is the absence of written direction governing how and when a residential visit in a non-criminal matter involving an individual with special needs should be conducted, irrespective of when officers become available to respond.

### Non-criminal residential visits involving vulnerable individuals

A door knock at 12:30 a.m. at the home of an individual with special needs, in a matter with no criminal dimension, raises questions that the Call Response Protocol does not address:

- When is it appropriate to conduct a residential visit in a non-criminal matter, particularly at night and where the subject is a vulnerable individual?
- How should officers approach and communicate with a developmentally disabled person who may not fully understand the implications of police contact?
- Should the interaction be directed, as a matter of standard practice, through the person's primary caregiver?

None of these questions is answered by any procedure the PSU was able to identify.

#### Board Policy LE-013 is outdated

The review considered whether any Board policy addresses OPS engagement with individuals with special needs. *Board Policy LE-013: Police Response to Persons who are Emotionally Disturbed or Have a Mental Illness or a Developmental Disability*, is the most directly relevant instrument. It was established in 2005 and has not been amended since. A review was conducted in 2022 but produced no amendments. Twenty years without substantive revision is a significant gap.

The policy predates the *Community Safety and Policing Act, 2019*, and the substantial evolution in community expectations regarding how police services should engage with vulnerable populations. This complaint provides a concrete and timely occasion to revisit this policy.

#### Policy scope: mental illness, mental health crises, and developmental disability

The policy's scope encompasses mental illness, mental health crises and developmental disability under a single instrument. While there may be overlap, including in cases of dual diagnosis, these are distinct populations that can present very differently in a policing context. Developmental disabilities are generally lifelong conditions involving intellectual, adaptive, communication, social, or other functional limitations. They should not be presumed to constitute acute mental illness or psychiatric crisis, and the approach warranted when engaging an individual whose behaviour reflects a developmental disability will often differ from the approach appropriate in a mental health crisis. In this respect, LE-013 goes further than the policies of some other police service boards in Ontario, which address only persons in crisis and do not recognize individuals with developmental disabilities as a distinct population within their scope. That distinction is to the policy's credit. What the policy does not do, however, is carry that recognition through into distinct guidance. It does not identify where different approaches are warranted, does not address the particular considerations that arise when engaging with an individual who may have limited capacity to understand the implications of police contact, and does not prescribe different practices for different circumstances.

#### LE-13: An instrument without operative effect

A further observation concerns the substance of the instrument itself. Board Policy LE-013 is characteristic, in its structure, of policies established under the *Police Services Act, 1990*: in form a governance instrument, but in substance a devolution of the Board's own responsibility – as representative of the public interest in policing – to

translate community expectations into effective direction to the police service. The policy contains no articulation of a value, a principle, or an outcome that OPS interactions with individuals should serve or achieve.

Read in its terms, LE-013 consists of three directions to the Chief: to work with community partners where possible, to establish procedures and processes addressing police response to these individuals, and to ensure that training addresses local protocols and conflict resolution, without indicating what those procedures should accomplish, what interests they are designed to protect, or what a well-conducted interaction should produce.

The Board, in effect, transferred the entire substantive question to the Chief without providing the direction that would allow it to assess whether the Chief's response was adequate, because no standard had been established against which adequacy could be measured. A policy framed at that level of generality may not provide the clarity or direction required to function effectively as a governance instrument.

The transition to the *Community Safety and Policing Act, 2019* has since clarified how boards are expected to discharge their statutory duty to ensure the provision of adequate and effective policing. The new framework requires the Board to establish governance direction that gives practical effect to the applicable adequacy standards.

In particular, Section 2 of Ontario Regulation 392/23 now sets out the Generally Applicable Standard for adequate and effective policing. That standard requires policing to be responsive to, among other things, the policing needs of the community and best practices. The Board's adequacy policies are the principal governance instruments through which that standard is translated into direction to the Chief. They should therefore do more than restate broad categories of service. They should guide the outcomes which the Board, on behalf of the community, expects and the considerations that must inform the Service's approach.

A policy which delegates the definition of community needs to the Chief, without the Board having formed and expressed a view of its own, does not appear to meet the standards laid out in the new adequacy regulation. The review of LE-013 is therefore not simply a matter of updating a dated instrument. Rather, it is an opportunity to discharge, in substantive terms, what the Board's adequacy obligations have always required and what the current regulatory framework now makes explicit. The procedural gap surfaced by this complaint was, in that light, a foreseeable consequence of a framework that had identified a subject without defining what it sought to achieve within it.

The review of LE-013 is an opportunity to do what the policy has never done: to identify what is to be protected, what outcomes should be sought, and what those commitments mean in practice for how OPS engages with this population.

Recommendation: review in consultation with the Mental Health Advisory Council

The review of LE-013 recommended here should be conducted in consultation with the Ottawa Police Service's Mental Health Advisory Council (MHAC). The MHAC was established in January 2025 in direct response to the Inquest into the Death of Mr. Abdirahman Abdi, which produced recommendations with a significant focus on improving police response to individuals experiencing mental health crises and on creating enduring community advisory mechanisms. The MHAC consists of 15 members, including community representatives with lived experience and subject matter expertise, and is co-chaired by a community representative and an OPS representative. It is structured under the Mental Health Change Initiative and reports quarterly to the OPS Executive and to the Board.

As of Q1 2026, MHAC has moved beyond its orientation phase into structured advisory work: formal work packages have been established, sub-committees formed, and its Policy Committee has begun reviewing OPS policies through a trauma-informed, anti-racism, and lived-experience lens.

The MHAC is the most appropriate body to inform a review of LE-013 because it is the only structured community advisory mechanism in OPS governance with the requisite expertise, lived experience, and community reach to ensure that a revised policy reflects current expectations rather than the institutional assumptions of 2005.

Although the Chief retains authority under the CSPA to initiate changes to operational procedures independently of a Board policy review, a coordinated approach is recommended. The risk of proceeding on two tracks – the Chief revising procedures operationally while the Board conducts a separate policy review – is that the resulting framework lacks coherence and community grounding. A review of LE-013 conducted in consultation with MHAC, and involving coordinated input on both Board policy and the Chief's implementation procedures, is more likely to produce direction that is consistent across levels, and responsive to the communities most affected. The specific gap identified in this complaint – i.e. the absence of written guidance on residential visits involving vulnerable individuals, including their timing and conduct – should be explicitly addressed within the scope of the review.

## **CONSULTATION**

N/A

## **FINANCIAL IMPLICATIONS**

N/A

## **SUPPORTING DOCUMENTATION**

Document 1: Inspector General Referral Letter to Chair Fakirani, INV-25-189

Document 2: Complaint document

Document 3: Board Policy LE-013, Police Response to Persons who are Emotionally Disturbed or Have a Mental Illness or a Developmental Disability

Document 4: OPS Call Response Protocol

Document 5: OPS Computer-Aided Dispatch Log, Call 25000252395

Document 6: Communication from the Chief of Police to all members re Priority 3 and 4 call notification practices

## **CONCLUSION**

What the complainant's family experienced on the morning of September 18, 2025 was unreasonable, unnecessary under the circumstances, and understandably traumatizing. The gap that produced it is institutional: no written procedure existed to guide when or how a residential visit of this kind should occur, and the Board policy that should have provided that direction has not been substantively revised in twenty years and does not, in its current form, give practical effect to what the Board's adequacy obligations require.

The recommendations in this report address both of those gaps. They call for the Chief to develop written procedure governing OPS response to non-criminal incidents involving individuals with developmental disabilities, including guidance on the timing and conduct of residential visits, and for the Board's Policy and Governance Committee to undertake a substantive review of Board Policy LE-013. That review, this report recommends, should be conducted in consultation with the Ottawa Police Service Mental Health Advisory Council – a body whose membership brings together community representatives with lived experience and subject matter expertise, and whose Policy Committee is already engaged in reviewing OPS procedures through a trauma-informed and lived-experience lens. Their involvement is expected to ensure that the revised policy reflects the real experiences and expectations of the communities it is meant to serve. The complainant's decision to bring this matter forward has made it possible to identify and begin to remedy them.