

**Report to / Rapport au:**

**OTTAWA POLICE SERVICE BOARD  
LA COMMISSION DE SERVICE DE POLICE D'OTTAWA**

**27 January 2025 / 27 janvier 2025**

**Submitted by / Soumis par:**

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**SUBJECT: INQUEST INTO THE DEATH OF ABDIRAHMAN ABDI: RECOMMENDATIONS**

**OBJET: ENQUETE SUR LE DECES DE ABDIRAHMAN ABDI : RECOMMANDATIONS**

**REPORT RECOMMENDATION**

**That the Ottawa Police Service Board:**

- 1. Receive this report for information and discussion.**
- 2. Direct the Policy and Governance Committee to review this report, including the jury recommendations, and provide advice to the Board on any required policy changes to address the recommendations and any further actions to address lessons learned and insights from the inquest into the death of Abdirahman Abdi.**
- 3. Direct the Chief of Police to submit a report at the March 2025 meeting detailing the Ottawa Police Service's response to the jury recommendations, including a timeline for implementation and any identified challenges.**

**RECOMMANDATION DU RAPPORT**

**Que la Commission de service de police d'Ottawa :**

- 1. prenne connaissance du présent rapport aux fins de discussion;**
- 2. demande au Comité des politiques et de la gouvernance d'examiner le présent rapport, y compris les recommandations du jury, et de lui fournir des conseils au sujet de tout changement devant être apporté aux politiques en vue de suivre les recommandations émises et de toute nouvelle mesure visant à répondre aux leçons tirées et aux constatations de l'enquête sur le décès d'Abdirahman Abdi;**

- 3. demande au chef de police de soumettre un rapport à la réunion prévue en mars 2025, détaillant la réponse du Service de police d'Ottawa aux recommandations du jury, en y ajoutant un calendrier de mise en œuvre et une liste des défis cernés.**

## **BACKGROUND**

Abdirahman Abdi, a 38-year-old Black man with mental health challenges, died on July 25, 2016, following an interaction with members of the Ottawa Police Service (OPS) in the Hintonburg neighborhood on July 24, 2016. The incident began when police were called to investigate reports of disturbances at a nearby establishment. Mr. Abdi fled the scene, and a foot chase ensued, culminating in his apprehension near his residence.

Video evidence from the scene captured elements of the interaction, including the use of physical force by police officers. Following his arrest, Mr. Abdi went into medical distress and later died in hospital. His death sparked widespread public concern and calls for greater transparency, accountability, and equity in policing.

The officer directly involved in the physical altercation, Constable Daniel Montsion, faced criminal charges, including manslaughter and assault with a weapon. In October 2020, Constable Montsion was acquitted of all charges.

The death of Mr. Abdi remains a significant moment in the community's relationship with OPS, and highlights the need for ongoing improvement in the areas of mental health response, use of force, and systemic bias. It has also informed broader conversations about equity, diversity, and inclusion within policing practices.

An inquest into the death of Abdirahman Abdi was initiated by Ontario's Office of the Chief Coroner (OCC) on November 18, 2024, and concluded on December 17, 2024. Inquests inform the public about the circumstances of a death without assigning blame or legal fault. They aim to identify lessons that could improve safety and prevent future deaths. Juries often provide non-binding recommendations, which, if implemented, can help address similar risks in the future.

The Ottawa Police Service Board and the Ottawa Police Service were granted separate standing at the inquest. Vice Chair Marty Carr provided testimony on behalf of the Board on December 12, 2025.

The inquest examined the circumstances surrounding Mr. Abdi's death and resulted in several jury recommendations aimed at improving police interactions with individuals experiencing mental health crises and addressing concerns regarding racism and intersectionality.

On January 17, 2025, the jury's recommendations were forwarded to the Board by the Office of the Chief Coroner. In its correspondence, the OCC noted that the jury's recommendations are not binding but requested a formal response from the Board by July 17, 2025.

## **DISCUSSION**

On December 18, 2024, the jury made three recommendations to the Ottawa Police Service Board and thirty-one recommendations to the Ottawa Police Service, including three directed at OPS and the Ontario Police College jointly.

## Recommendations to the Ottawa Police Service Board

### Recommendation #26: Policy on section 81 reports

The jury recommended that:

“The Board should continue developing a policy for CSPA section 81 reports that specifies the information and level of detail required and includes a formal tracking system to ensure that the Board receives all reports.”

Section 81 of the *Community Safety and Policing Act, 2019* mandates that when the Special Investigations Unit (SIU) Director initiates an investigation under section 15 of the *Special Investigations Unit Act, 2019* involving a police officer, the chief of police must investigate the officer's conduct, the policing provided, and the procedures related to the incident. Under the *Police Services Act, 1990*, in force at the time of Mr. Abdi's death, such reports were called "section 11 reports," referencing Ontario Regulation 267/10, which governed police conduct during SIU investigations. Section 81 reports apply to incidents involving potential criminal conduct by an officer resulting in death, serious injury, firearm discharge at a person, or sexual assault. Similar to section 11, section 81 requires the chief of police to submit a report on the investigation to the police service board.

Following the death of Mr. Abdi, both the SIU and the Service conducted an investigation as required under section 11. However, the Service failed to provide the Board with a report on the investigation. This omission was unusual, as the Service routinely submits section 11/81 reports, which are reviewed and published as part of the Board's agendas. After the inquest concluded, the Service noted the following in its media released dated December 19, 2024:

“During the proceedings, it also became evident that a section 11 report to the Ottawa Police Service Board (OPSB) had been overlooked. The OPS acknowledges the importance of section 11 reports in ensuring transparency and accountability to the OPSB and commits to adhering to this critical process in the future.”

While a Board policy is not necessary to compel the chief of police to submit a section 81 report, as this is already a legislated duty, developing such a policy would be beneficial. It would allow the Board to clearly define its expectations regarding the level of detail and scope of information to be included in these reports. The recommended policy would also involve a tracking system to prevent similar omissions from occurring in the future.

At its December 2, 2024, meeting, the Board passed a motion directing Board staff to initiate the development of a policy regarding reporting requirements under section 81 of the CSPA under the supervision of the Policy and Governance Committee. This motion aligns with the jury's recommendation.

### Recommendation #27: New member orientation

The jury recommended that:

“The Board should provide new Board members with relevant inquest recommendations as part of their onboarding package.”

Including information about inquest recommendations in the onboarding materials for new Board members is valuable as it highlights critical lessons learned from past incidents and underscores the importance of addressing systemic issues identified through such inquiries. This practice would ensure that new members are aware of prior recommendations, fostering continuity and informed decision-making. It would also reinforce the Board’s commitment to accountability and to the ongoing improvement of policing practices and enable members to contribute effectively to governance and oversight responsibilities from the outset.

In January 2025, as part of onboarding Mr. Polowin who was recently appointed as a Board Member, the Executive Director updated the *New Board Member Orientation* package, partially in response to the jury’s recommendation. The updated materials highlighted the Abdi inquest recommendations as one of the Board’s current priorities. The package included a copy of the inquest verdict and summaries of key reports such as the Morden, Epstein, and Sinclair reports, ensuring the new member received comprehensive resources to support informed governance and oversight.

The Board may consider requiring the inclusion of relevant inquest recommendations in the Members’ onboarding package as part of a review of Board Policy No. GA-3 *Board Training*.

#### Recommendation #28: Analysis of use of force data

The jury further recommended that:

“The Board should consult with external experts in the field of statistics upon receiving the Annual Use of Force Report to ensure an accurate interpretation of the data is applied to strategic and other oversight decision.”

Subsection 17(6) of Ontario Regulation 391/23 requires the Chief of Police to submit an annual report to the Board, analyzing data regarding use of force by members of the Service and identifying any trends.

The Annual Use of Force Report provided by the Service is compliant with the regulation and includes data disaggregated by the subject’s perceived race and gender, as well as historical trends – although the inquest highlighted potential improvements in that area.

An independent analysis of the use of force data provided by the Service is essential to enable the Board to effectively fulfill its oversight and monitoring responsibilities. Such an analysis ensures that the data is evaluated objectively, free from potential biases. Such an approach not only enhances the Board’s ability to hold the Service accountable for its practices but also supports evidence-based decision-making and policy development.

Consultation with external experts in statistics can provide valuable insights to enhance the interpretation of the Annual Use of Force Report and support informed oversight decisions. While consultation would be beneficial, it may not need to occur systematically on a yearly basis. Instead,

periodic engagements with external experts, particularly for in-depth studies, could complement existing analytical capabilities and provide targeted analysis when required.

The Board is currently in the process of hiring a Senior Policy Advisor in accordance with its Staffing Strategy adopted in October 2023. The position, once filled, will strengthen the Board's capacity for independent analysis of policing data, including use of force data. With this enhanced in-house expertise, the regular interpretation and analysis of use of force data should be sufficiently addressed without needing external support for routine reporting.

However, there is merit in considering an external study on use of force practices to provide a detailed examination of trends, underlying drivers, and disproportionalities. Such a study, which could involve experts in statistics and other subject-matters, could complement ongoing efforts and provide strategic insights. It would also be beneficial to coordinate this with the Community Equity Council's civilian case review panel, which aims to analyze use of force incidents, to ensure that duplication of efforts is avoided.

To enable meaningful analysis of use of force data, adjustments to the current reporting process could be considered. Currently, the only opportunity for discussion of a report is during the Board meeting for which it is scheduled. Reports, such as the Annual Use of Force Report, are submitted by the service 7 to 10 days before the meeting. While this timeline allows for initial review and staff analysis, it does not provide sufficient time for in-depth evaluations, particularly if external expertise is involved.

The reporting process could be refined to allow earlier submission of key reports to enable comprehensive analysis ahead of meetings.

An adaptable review approach could transform the process of receiving monitoring reports into a more dynamic and iterative process that includes structured options for assessment and follow-up actions. Rather than systematically accepting reports submitted to the Board for information, this approach would enable the Board to actively evaluate their content and prescribe further actions as needed.

There are precedents for such an approach, such as the Monitoring Report Scorecard introduced at the Durham Police Services Board in the early 2000s. This model provided structured options for assessing reports, identifying areas requiring further clarification, and directing specific follow-up actions.

This could include options for:

- Highlighting specific areas of concern or gaps in the information provided.
- Requesting additional data or analysis to address unresolved questions or clarify findings.
- Offering feedback on the report's methodology or scope, with the option to direct revisions or updates.
- Initiating follow-up actions, such as requesting supplementary reports or commissioning external studies on identified issues.

By adopting a flexible and responsive model, the Board would enhance its ability to use monitoring reports as tools for meaningful oversight, driving strategic decisions, and addressing emerging concerns effectively.

### **Recommendations to the Ottawa Police Service**

The Service is currently reviewing all jury recommendations. Although recommendations to OPS do not require any direct action from the Board, it is recommended for the Board to monitor the implementation of these recommendations. Doing so can help ensure that the insights and recommendations from the inquest are effectively addressed. Monitoring the Service's response to the jury's recommendations would allow the Board to remain informed about progress, and support alignment between the Service's actions and the Board's strategic plan and policies.

Additionally, the Board may consider establishing policies to reinforce specific recommendations or govern their implementation if gaps or areas requiring clearer guidance are identified.

However, it is advisable for the Board to wait until the Service has completed its review of the jury recommendations and outlined its work plan for addressing them before intervening in these areas.

### **Additional areas for Board consideration**

While the inquest recommendations do not specifically direct additional action to the Board beyond those already discussed, there are other areas that the Board may wish to explore to further address the broader themes and insights that emerged from the inquest. These areas, although not directly tied to the jury's recommendations to the Board, align with the Board's mandate.

#### Body-Worn Cameras

Recommendation #20 emphasizes the need for OPS to assess the timing and manner of introducing Body-Worn Cameras (BWCs), considering their role in supervisors' review of use of force incidents, evaluating the effectiveness of use of force and de-escalation training, and using BWC recordings as learning tools.

While this recommendation is directed at the Service rather than the Board, it is worth noting that the deployment of BWCs, originally planned for 2025, has been postponed to 2026 due to budgetary constraints. Ensuring adequate funding in 2026 will be critical to support this initiative. In other jurisdictions, such as Peel, BWCs have shown potential to enhance accountability and contribute to a reduction in the overall use of force during police interactions.

#### Advisory Committees

During the inquest proceedings, parties initially suggested that the Board should create advisory committees on both racism and mental health. However, these specific recommendations were not adopted by the jury, which instead recommended the creation of a Mental Health Advisory Council under OPS. The proposed Council would provide recommendations to OPS regarding its interactions with individuals experiencing mental health issues or crises and would include members of the OPS executive leadership and representatives from peer-run organizations representing individuals with

lived experience. Importantly, the recommendation also specifies that this Council should engage regularly with the Board.

Although the recommendation for Board-led advisory committees was not endorsed, this insight aligns with broader trends and best practices in policing governance. It echoes findings from the inquest into the death of Andrew Loku in Toronto, which highlighted the critical role of police governance bodies in addressing mental health and systemic racism. Among the recommendations from the Loku inquest was for the Toronto Police Services Board to maintain its Sub-Committee on Mental Health – later expanded into the Mental Health and Addictions Advisory Panel – and to create an Anti-Racism Advisory Panel, both of which continue to serve as platforms for community engagement.

These examples illustrate that it is a recognized best practice for police service boards to establish community advisory panels. Such panels provide an avenue for meaningful dialogue with diverse communities, foster transparency, and support the development of strategies and policies that address community needs. This practice is particularly significant under the *Community Safety and Policing Act, 2019* (CSPA), which emphasizes the responsibility of police service boards to engage with the communities they serve and to ensure that their strategies and policies are responsive to those communities' needs and priorities.

The Board may wish to consider establishing a Community Advisory Panel to bring together representatives from Ottawa's diverse communities, creating a structured forum for meaningful input into Board policies and strategies. The panel would address issues such as mental health, equality, diversity, and inclusion, while maintaining a broader mandate to ensure that a wide range of community concerns are heard and reflected in the Board's governance practices. Such a panel would provide valuable insights into community priorities, foster trust and transparency between the Board and the public, and ensure alignment between the Board's strategies and policies with the needs of the communities it serves.

This initiative could be pursued particularly after the hiring of a Communications and Stakeholder Relations Advisor, as outlined in the Board's Staffing Strategy. This advisor would play a key role in coordinating the establishment of the panel, managing its operations, and ensuring that its work is effectively integrated into the Board's decision-making processes.

## **FINANCIAL IMPLICATIONS**

The financial implications of this report would depend on the specific actions the Board decides to undertake in response to jury recommendations and related considerations. Potential cost areas include:

- No additional costs expected for staff time and resources allocated to developing a policy on section 81 reports and updating onboarding materials.
- Establishing a Community Advisory Panel involves the hiring of a Communications and Stakeholder Relations advisor, meeting expenses such as venue bookings and materials, and potential compensation for community representatives.

- Engaging external experts to analyze use of force data or conduct other specialized reviews would involve costs, primarily consulting fees. Periodic studies could be more cost-effective than annual consultations.
- The deployment of Body-Worn Cameras would require significant investment. Updated costs may be discussed with the Service at the Finance and Audit Committee.

## **SUPPORTING DOCUMENTATION**

Document 1 – OCC Letter of Implementation

Document 2 – Abdi Inquest Verdict

## **CONCLUSION**

The recommendations made by the jury in the inquest into the death of Abdirahman Abdi present an opportunity for the Ottawa Police Service Board to strengthen its role in ensuring accountability. These recommendations, which focus on improving oversight, governance, and interactions with racialized individuals and those who are experiencing mental health crises, provide a pathway for the Board to further align its policies with the needs and expectations of the diverse communities it serves.

This report has outlined the steps already taken by the Board to address the recommendations directed at it, including progress toward developing a policy on section 81 reports, which is currently underway, and the incorporation of inquest recommendations into the orientation materials for new Board members. It has also highlighted additional areas for consideration, such as the establishment of a Community Advisory Panel, enhanced mechanisms for monitoring use of force, and the Board's role in a future deployment of Body-Worn Cameras.

While many of the recommendations are directed at the Ottawa Police Service, the Board has an important role in monitoring their implementation and ensuring alignment with its policies and priorities.