

Report to / Rapport au:

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

5 December 2025 / 5 décembre 2025

Submitted by / Soumis par:

Chief of Police, Ottawa Police Service / Chef de police, Service de police d'Ottawa

Contact Person / Personne ressource:

**A/Superintendent Mazen Dikah, Executive Officer to the Chief of Police
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SUBJECT: REPORT ON THE SPECIAL INVESTIGATIONS UNIT 25-OCD-105

**OBJET: RAPPORT SUR L'UNITÉ DES ENQUÊTES SPÉCIALES – ENQUÊTE
25-OCD-105**

REPORT RECOMMENDATIONS

That the Ottawa Police Service Board receive this report for information.

RECOMMANDATIONS DU RAPPORT

Que la Commission de service police d'Ottawa prenne connaissance du présent rapport à titre d'information

BACKGROUND

This document outlines a police interaction that resulted in the Special Investigations Unit (SIU) invoking their mandate. The background of the incident, along with SIU findings and recommendations are provided. As required by legislation, the Professional Standards Unit (PSU) subsequently completed an investigation into the policing services delivered, the procedural practices and the conduct of the Ottawa Police Service (OPS) in relation to this incident.

DISCUSSION

Incident Summary – March 17, 2025

On March 13, 2025, at approximately 1840 hours, members of the Ottawa Police Service were dispatched to 1379 Bank Street following a 911 call reporting an individual actively setting a fire.

Upon arrival, officers were flagged down by a witness who directed them to a porta-potty where the suspect—later identified as the complainant—was located. The complainant was found in possession of a lighter and a knife.

The complainant was subsequently arrested for several criminal offences and transported to the central cellblock. At the time of the incident, the complainant was not abiding by their release conditions.

Following the arrest, the complainant was charged with multiple criminal offences and held in custody at the Regional Detention Centre (RDC) until March 17, 2025. On that date, they were transported to Provincial Court at 161 Elgin Street for a scheduled appearance.

While in custody, the complainant used their clothing and tied them around their neck and the cell bars. This act was not witnessed by any Ottawa Police Service personnel assigned to the cellblock.

At approximately 1130 hours, a Special Constable (Service Employee Witness - SEW) discovered the complainant unresponsive in the cell, with clothing tied around their neck. Immediate life-saving efforts including CPR, mouth-to-mouth resuscitation, and defibrillator were initiated by several Special Constables (SEW). The complainant was transported to hospital, where they were later pronounced deceased.

INVESTIGATIONS

SIU Investigation:

On July 15th, 2025, the OPS received a letter from the Director of the SIU concerning the outcome of their investigation. The SIU collected evidence, including interviews with police and non-police witnesses and video footage. In his letter, Director Martino stated that the file has been closed and no further action being contemplated. He was satisfied that there were no grounds in the evidence to proceed with criminal charges against the Subject Official who was involved in this incident. The SIU investigative report was also disclosed to the Chief.

The SIU collected evidence, including interviews with police witnesses, video footage and radio communications. In his report the SIU Director stated: “Whether the aforementioned-conduct on the part of the special constables fell short of expectations, I am unable to reasonably conclude that it transgressed the limits of care prescribed by the criminal law. Nothing short of dedicated, continuous monitoring of the Complainant would have guaranteed detection of her efforts at self-harm before it was too late, but there was nothing in the record available to the special constables that suggested the

Complainant was suicidal and in need of constant supervision. It is true that the Complainant would have been discovered sooner had not more than 30 minutes lapsed from the moment she was last with a special constable. However, whether a check at the 30-minute interval would have made any difference remains a matter of speculation. The Complainant had been hanging for about 20 minutes before the 30-minute mark had expired at about 11:15 a.m. and might well have been beyond the point of no return by that time. A delay of about 20 minutes past the 30-minute personal check marker would also not appear particularly egregious, nor the fact that the Complainant's behaviour was not detected on video screen by Service Employee Witness (SEW #2), amid evidence that there were upwards of 40 prisoners in the cell area of the courthouse at one time or another, each of whom would have required attention.

On this record, I am not persuaded on balance that there is sufficient evidence to reasonably believe that the care afforded the Complainant fell markedly below a reasonable standard in the circumstances, much less that it amounted to a marked and substantial departure from that standard".

Professional Standards Unit Investigation:

Pursuant to Section 8 of Ontario Regulation 90/24, Section 81 of the Community Safety and Police Act (CSPA), PSU initiated an investigation into this incident to review the policing services, the procedural practices of the OPS, and to determine if the conduct of the involved police members was appropriate.

During the PSU investigation, it was determined that while the Subject Official and Special Constables (Service Employee Witnesses) conducted themselves in accordance with the Code of Conduct, a cell check was delayed by 20 minutes contravening procedures. This lapse created an opportunity for the complainant to tie clothing around their neck to take their own life.

The investigation further revealed that, due to the high volume of prisoner movement and operational demands, video monitors were temporarily left unsupervised and cell checks were not completed on schedule while staff attended to other duties. These procedural breaches have since been addressed to prevent recurrence.

To enhance oversight and safety within the cellblock, a second dedicated video monitoring position has been established to ensure continuous surveillance of cell cameras. Additionally, a tracking system has been implemented to record the movement of all individuals, including OPS members, within the area. These measures aim to strengthen accountability and create a safer environment for everyone in custody.

Policing Services Findings – No issues identified.

Procedural Practices Findings – One issue identified. This was addressed through internal processes to mitigate future risks.

Conduct Findings – No issues identified.

CONCLUSION

PSU has completed its Section 81 investigation into this incident and no further action is required.