Report to / Rapport au:

OTTAWA POLICE SERVICES BOARD
LA COMMISSION DE SERVICES POLICIERS D'OTTAWA

24 September 2018 / 24 septembre 2018

Submitted by / Soumis par:
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SUBJECT: REPORT ON OFFICE OF THE INDEPENDENT POLICE REVIEW DIRECTOR INVESTIGATION

OBJET: RAPPORT SUR L'ENQUÊTE DU BUREAU DU DIRECTEUR INDÉPENDANT DE L'EXAMEN DE LA POLICE

REPORT RECOMMENDATIONS

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

RECOMMANDATIONS DU RAPPORT

Que la Commission de services policiers d'Ottawa prenne connaissance du présent rapport à titre d'information.

BACKGROUND

This report outlines an incident that resulted in two public complaints being made to the Office of the Independent Police Review Director (OIPRD). Both complaints were made by third parties who had no direct link to the affected person or any direct knowledge of the incident. The matters were classified as conduct complaints against unidentified Ottawa Police Service (OPS) officers and pursuant to S. 61(5)(c) of the *Police Services Act (PSA)*, the complaints were retained by the OIPRD for investigation. The background of the incident and the OIPRD findings are provided.

DISCUSSION

In February 2013, an emaciated and abused 9 year old boy (the “affected person”) was found by a neighbour. The father of the child was an RCMP officer at the time. As a result of the OPS investigation into the matter, both the father and the step-mother were charged with several serious offences.

In 2016, the arrest and subsequent trial was widely reported by local and national news outlets.

During the trial, an earlier call to the same address on October 9, 2011 involving the same child that was responded to by OPS members was discussed.

Three officers had responded to a report of a missing child. The child was located at a nearby home. The officers investigated the circumstances of the missing child and returned him to the home when it was determined it was safe.

The first complainant to the OIPRD alleged that OPS failed to protect the affected person in 2011 and that because the affected person’s father was a police officer, the attending officers were biased in favour of the father.

The second complainant to OIPRD alleged officers failed in their duty when they did not report the incident to the Children’s Aid Society (CAS). The complainant felt that this neglect by the attending officers suggested that the father was not properly dealt with because he was a police officer.

Synopsis of the OIPRD Investigation

Based on those complaints, the OIPRD identified the following two Code of Conduct allegations:

Neglect of Duty, contrary to s. 2(1)(c)(i) of the Code of Conduct, PSA – without lawful excuse, neglects or omits promptly and diligently to perform a duty as a member of the police force.

More specifically, the allegation was that the respondent officers failed in their duty when they did not report the incident to the CAS.

Discreditable Conduct, contrary to s. 2(1)(a)(xi) of the Code of Conduct, PSA – acts in a disorderly manner or in a manner prejudicial to discipline or likely to bring discredit upon the reputation of the police force.

More specifically, the allegation was that the respondent officers did not properly deal with the incident and gave preferential treatment to the father because he was a police officer.

The OIPRD conducted the investigation and reported their findings to the OPS on September 6, 2018.

OIPRD Conclusion

On September 6, 2018, the OPS received a letter from Mr. Gerry McNeilly, Independent Police Review Director, enclosing the Investigative Report. The report outlined the investigation conducted by the OIPRD and its findings with respect to the two public complaints.

In his letter, Mr. McNeilly stated that “after carefully considering all of the available information, I am of the opinion that there is an insufficient body of evidence for me to determine that there are reasonable grounds to believe that misconduct occurred.” As such, his findings were that the complaints against the respondent officers were unsubstantiated.

These findings are very similar to an internal review conducted by OPS on the 2011 call for service. This internal review found that the child was also in contact with various professionals such as teachers, doctors and social workers none of whom reported any signs of abuse. The results of that OPS internal review were to have been previously presented to the Board. However, the OPS was directed by the OIPRD not to present the information to the Board while the OIPRD conducted its own investigation.

While neither review found any misconduct, the OPS internal review updated internal processes with recommendations. This included;

Directing that CAS workers read and review all occurrences of children under 12 reported missing.

The issuance of a training bulletin to OPS communications centre personnel making it mandatory to fully disclose all circumstances related to a missing child over the air (radio communication).

However, given the circumstances of the 2011 call for service, it is believed that had these recommendations been in place at the time, they would not have provided any indicators or alerts with regard to the tragic case of child abuse that was discovered years later.

CONCLUSION

The case of child abuse against this young boy was difficult for our entire community. It was important that all aspects of this case were reviewed to understand whether we as a police service could have done something different to prevent this tragedy.

The review by the OIPRD and an internal review by the OPS both came to the same conclusion, that there were no misconduct or service issues related to the officers who responded to the case of a missing child in October of 2011.