Inspectorate of Policing

Decision Regarding Findings Report INV-24-46 Concerning Policing Provided by the Niagara Regional Police Service

Decision By:
Ryan Teschner, Inspector General of Policing

I. INTRODUCTION

[1] This decision addresses a complaint received by the Inspector General of Policing against the Niagara Regional Police Service ("NRPS"), alleging that the NRPS failed to dispatch police officers after receiving a 911 call in the early hours of August 30, 2024. The next morning, the caller was found without vital signs on the floor of his kitchen by a family member. He was later pronounced dead.

[2] An inspector with Ontario's Inspectorate of Policing ("IoP") investigated the complaint to determine whether the NRPS (through the Chief of Police) or the Niagara Regional Police Service Board[1] ("NRPSB") failed to comply with the *Community Safety and Policing Act*, *2019*, SO 2019, c 1, Sch 1 (the "Act") or its regulations. Following a review of the inspector's Findings Report,[2] which is attached to this Decision as Appendix A, and for the reasons that follow, I conclude that the NRPSB and the NRPS have failed to: (i) provide adequate and effective policing in relation to call-taking and dispatch and (ii) implement the Quality Assurance process required by the Act and its regulations. As a result, I have issued a Direction to improve dispatch processes and procedures with increased clarity and consistency and to ensure that the legal requirement to apply Quality Assurance processes are adhered to.

[3] It is also important to be clear about what the legal character and result of my decision is, and what it is not. When it comes to evaluating and then making decisions about the delivery of adequate and effective policing or compliance with the Act and its regulations, my focus as Inspector General of Policing is to examine and analyze the overall legal requirements, systems, governance and environment in which a police service board makes its decisions and a chief of police operationalizes them through the police service. A matter that the IoP investigates may, and often does, relate to a single policing instance or interaction. Naturally, our investigation must examine the facts of that specific incident to understand the broader policing issues at play. However, the IoP investigation and my decision is <u>not</u> about the conduct of individual members of a police service, be they police officers or civilians.[3] Rather, where I determine, as I have here, that adequate and effective policing was not delivered in a particular circumstance, my decision is grounded in the application and interpretation of Ontario's policing laws, and

[1] While the complaint was about NRPS, under the Act, the legal responsibility to provide adequate and effective policing ultimately resides with the NRPSB. The legal responsibility to implement a Quality Assurance process similarly resides with the NRPSB and the NRPS Chief of Police.
[2] Section 123(1) of the Act requires an IoP inspector who completes an investigation of a complaint to report their findings to the Inspector General. This report is redacted to comply with the *Publication of Findings Reports and Directions under Sections 123 and 125 of the Act* Regulation, O Reg 317/24.
[3] Investigations into the conduct of individual police officers in Ontario is the jurisdiction of the Law Enforcement Complaints Agency (see Act, Part VIII).

reflects my assessment of whether the police service board and police service, viewed as institutions, achieved a reasonable overall level of service delivery and governance as required by law.

[4] While my role is about the overall policing system and the interpretation of Ontario's legal requirements for policing and its governance, there is an important human element behind our investigation and my Decision in this matter that should not be ignored. I wish to express condolences for the death of the individual that is the subject of his family's complaint. I am obliged not to provide information in this Decision that would identify the individual, which is why I am not referring to him by name. However, his family knows his name and knows their loss, and this must be acknowledged.

[5] Finally, while this is a decision that applies specifically to the NRPS and NRPSB, I strongly encourage all of Ontario's police services and boards to analyze this decision and determine how to incorporate it into their own organizations. Given the nature of the specific issues examined, my interpretation of the applicable legal requirements, and my ultimate Direction, others in Ontario's policing sector may need to examine their own approaches and make changes to align them with this decision.

II. BACKGROUND

a) Information from the complainant

i. The sudden death and the discovery of the 911 call

[6] The complainant was visiting his brother's home which is located in the area where the NRPS has policing responsibility, including the responsibility to provide 911 call-taking and dispatch services.

[7] On August 30, 2024, at approximately 8 a.m., the complainant was awakened by his niece, who had discovered the complainant's brother lying face down in the kitchen. A cell phone was laying near the hand of the deceased's extended right arm. The complainant's niece called 911 for an ambulance while the complainant began chest compressions. Unfortunately, when the paramedics arrived, the deceased was pronounced dead. The deceased had died from heart disease.

[8] After the paramedics and police left the home, the complainant and his niece retrieved the deceased's cell phone and provided it to the complainant's estate executor. A couple of days later, the estate executor contacted the complainant's sister to notify her of the discovery of a 911 call on the deceased's cell phone.

ii. The NRPS's dealings with next-of-kin

[9] On September 1, 2024, the estate executor called the NRPS and spoke to a detective about the 911 call on the deceased's cell phone. The detective later advised the complainant's sister that he had listened to a recording of the 911 call and heard a thump, followed by wheezing and exhaling. NRPS records also showed that the call taker did not receive a response to her questions, attempted a callback and "pinged" the cell phone to a 41-metre radius.[4] However, no NRPS officers were dispatched to the scene. The detective advised the complainant's sister that an internal investigation was underway. He characterized the situation as a "mistake."

[10] On October 28, 2024, an Inspector from the NRPS contacted the complainant and said the internal investigation was complete. The NRPS had determined that there was no misconduct on the part of the call taker. The complainant was told that the call taker had not heard anything in the call that caused her concern, which concerned the complainant because this contrasted with the earlier information provided by the NRPS Detective, which acknowledged noises on the recording of the 911 call.

[11] The complainant's sister attempted to obtain the recording of the 911 call and the sudden death investigation report completed by the NRPS by filing a request under the *Freedom of Information and Protection of Privacy Act*, RSO 1990, c F.31. The NRPS initially declined to release these records. However, the NRPS ultimately granted the complainant's sister a partial release of the records after she launched an appeal of the refusal to the Information and Privacy Commissioner of Ontario.

iii. The Chief of Police's dealings with next-of-kin

[12] On June 12, 2025, the complainant and his sister met with a Member of Provincial Parliament ("MPP") to discuss their concerns with the NRPS. The MPP subsequently sent a letter to NRPS Chief of Police Bill Fordy.

[4] "Pinging" a cell phone is a process that provides location information for a cell phone and requires the cooperation of the mobile service provider. The IoP's investigation revealed that, in fact, the call taker never "pinged" the cell phone but still had information about the cell phone's location which was automatically generated by the enhanced 911 system used by the NRPS.

[13] On July 17, 2025, the Chief of Police sent a letter to the complainant and his sister. The Chief of Police expressed his condolences and acknowledged "that the way the emergency call was managed was due, in part, to an error in process." In a subsequent phone call between the Chief of Police, Deputy Chief Luigi Greco, the complainant and his sister, the Chief of Police acknowledged that the organization struggled in distinguishing between a "mistake" and "misconduct."

[14] On July 25, 2025, the Chief of Police and two Deputy Chiefs met with the complainant and his two sisters to discuss the 911 call and response. At the meeting, a Deputy Chief confirmed that both the Professional Standards Unit and sudden death investigators had heard noises on the 911 call recording; however, the Deputy Chief advised that the call taker said she had not heard any sounds. This was not an accurate characterization of what the call taker said during the Professional Standards Unit investigation. Rather, the call taker stated that she had no memory of this specific call, but that if she had heard something that caused concern, she would have escalated her response.

[15] During the meeting, there was also discussion about the headphones used by NRPS call takers. It was acknowledged that call takers do not use noise-cancelling headphones and that, at times, the environment in which call takers perform their duties can become noisy.

b) Information from the NRPS

i. The 911 call

[16] The NRPS uses an enhanced 911 system which automatically generates a variety of information when a 911 call is made via cell phone. This includes the latitude and longitude of the cell phone making the call, including a radius of uncertainty, which is generated using signal triangulation of cell phone towers. This is known as "Automatic Location Identification." The cell phone number is also automatically generated which is known as "Automatic Number Identification."

[17] When there is a 911 call that indicates an imminent danger or risk to life, 911 operators can make a specific query to obtain additional information, including the frequency of calls to 911 from that phone number, and any previous calls and names associated with the number. The call takers can also contact cell phone providers to "ping" a phone for updated location information.[5]

[5] A "ping" is conducted because the initial "Automatic Location Identification" provides the location of the cell phone at the time the call came in but does not provide ongoing location information (*e.g.* if a caller is moving to different locations while connected with 911).

[18] The 911 call from the deceased's cell phone occurred on August 30, 2024, at 2:56 a.m. Upon receiving the 911 call, the NRPS's 911 system provided the usual information that is automatically generated, including the Automatic Location Identification. The Automatic Location Identification located the cell phone within a 41-metre radius of uncertainty, with the centre of the circle being directly over the deceased's home address. The call taker did not "ping" the phone. The call taker did, however, run a query on the number which showed that this was the first time that phone number had called 911.

[19] I have listened to the recording of the 911 call. It captured the call taker asking the caller what emergency services were required ("police, fire or ambulance?"), and then later asking, "can you hear me?" without a response from the caller. The recording also captured the following noises:

- At the 4-second mark, there was a sound like someone had dropped something or fallen down.
- At the 14-second mark, laboured breathing was evident in the background of the call, and it became even more apparent at the 20-second mark.
- From the 23 to the 36-second mark, deep breathing was obvious and sounds like snoring were heard.
- At the 36-second mark, the call was disconnected while laboured breathing was still audible and evident.

[20] The call taker cleared the call as a "silent call" and did not generate a call for service. As a result, no NRPS officers or any other emergency personnel were dispatched to the deceased's home. The deceased was ultimately discovered approximately five hours later by his niece and was not responsive.

ii. The sudden death investigation

[21] The NRPS sudden death investigation report makes no reference to the 911 call on August 30, 2024, at 2:56 a.m. or to the deceased's cell phone. The investigating officer's supplementary report also makes no mention of the deceased's cell phone. None of the family members interviewed mentioned the cell phone on the kitchen floor in their descriptions of what they saw when they discovered the deceased (this is reasonable, given that the estate executor only discovered the 911 call placed on the deceased's cell phone following these interviews). However, photographs taken during the sudden death investigation captured two cell phones at the scene.

[22] An addendum to the sudden death investigation report describes the investigator learning that a 911 call had been discovered on the deceased's cell phone by the estate executor. This appears to be the first time the NRPS discovered the 911 call. Interestingly, the investigating officer reports that the deceased's phone "was not accessible during the time the police were on the scene." It is unclear why that comment is made, particularly as two cell phones were present at the scene.

iii. The initial briefing note

[23] The first in a series of internal NRPS briefing notes, dated September 2, 2024, acknowledges the NRPS receiving the 911 call and describes the call taker's actions. The briefing note ends with an observation from the NRPS Communications Supervisor: "Call for service should have been generated following the 911 SOP [Standard Operating Procedure] Sec 5.1.2 due to the small radius of the 911 drop and background noise heard. [emphasis added]

iv. Procedure and training about call-taking and dispatch

[24] The NRPS communications procedures incorporate many of the National Emergency Number Association standards, which are treated as best practices by the Ontario policing sector.

[25] The NRPS's Communications Unit Standard Operating Procedure OP-003 (the "SOP") specifically addresses "silent calls" from a cell phone. A "silent call" is defined as one where there "may be silence on the line or the Call Taker can hear a disturbance and unable to make voice contact with the caller."

[26] Section 5.2.2 of the SOP states that, "A silent cell call shall not be cleared until it has been established that the caller doesn't require any assistance by using all measures necessary." The SOP also states that if the call taker cannot make voice contact with the caller, "but there are sounds to cause concern," then the call taker must use the Automatic Location Identification "to enter a call for service." The SOP also requires that the call taker complete a query on the cell phone number to obtain information about prior call history.

[27] The concepts "all measures necessary" and "sounds of concern" are not defined in the SOP.

[28] The NRPS provides communications training to all call takers. This training includes information about the SOP. While "sounds of concern" is not defined, the training canvasses examples of sounds that would not be deemed to cause concern, such as traffic noise, conversational talking to another individual and the sound of a cell phone moving in someone's pocket.

v. The Professional Standards Unit investigation

[29] An internal memorandum, dated September 4, 2024, and signed by the Acting Chief of Police (at the time it was signed), approved a Professional Standards Unit investigation into this incident. The investigation by the NRPS Professional Standards Unit was meant to determine whether misconduct occurred as a result of the actions or omissions of the call taker.

[30] The Professional Standards Unit investigation report compares the call taker's actions with the SOP for 911 calls. It concludes that the call taker classified the call as a "silent call," despite the audio revealing "sounds to cause concerns."

[31] The report also concludes that there was information available pertaining to the location and origin of the 911 call, but that this information was not investigated. Importantly, the report concludes that the call should not have been cleared until it had been established that the caller did not require any assistance, and that all measures necessary should have been deployed to make this determination.

[32] The report goes on to state that there was no "malice or intent" on the part of the call taker, and, for reasons unclear, identifies as a "mitigating" circumstance that other parties in the deceased's home failed to respond to the 911 callback.

[33] The report did not address whether, while potentially not misconduct, the call taker may have made a mistake, or – and of significance to my Decision – whether the SOP or other direction in place for call takers was reasonable.

vi. Additional actions of the NRPS

[34] In addition to the Professional Standards Unit investigation, the NRPS circulated a "silent cell" 911 training bulletin, dated September 4, 2024, to its Communications Unit. The definition of "silent cell" is identical to what is found in the SOP, but now contains this new addition: "When in doubt, ask a Supervisor! They can play the call back and help you determine if there are any unconfirmed background noises, sounds of a struggle, etc." This explicit direction for a call taker to seek assistance from a Supervisor when there is uncertainty about unconfirmed background noises during a silent call was not in place at the time of the deceased's 911 call to the NRPS.

[35] In January of 2025, the NRPS also conducted a jurisdictional scan to ascertain how other Primary Public Safety Answer Points ("PSAPs") handle cell phone calls where no voice contact can be established. The jurisdictional scan included responses from PSAPs in York Region, Windsor, Thunder Bay, Ottawa and Waterloo Region. According to the NRPS, all of those organizations clear a 911 cell phone call with no call for service where no voice contact is established.

III. ISSUES

[36] This investigation raises two issues:

1. Whether the NRPSB provided adequate and effective policing related to the dispatching function of the NRPS, and
2. Whether the NRPSB and NRPS (through the Chief of Police) implemented the required Quality Assurance processes.

IV. ANALYSIS

Issue 1: The NRPSB failed to provide adequate and effective policing related to their dispatching function.

a) <u>The requirement to provide adequate and effective policing</u>

[37] In Ontario, police service boards and the Ontario Provincial Police Commissioner are required to ensure adequate and effective policing is provided locally. This duty is contained in section 10(1) of the Act, which states:

> 10 (1) The police service boards and the Commissioner shall ensure adequate and effective policing is provided in the area for which they have policing responsibility in accordance with the needs of the population in the area and having regard for the diversity of the population in the area.

[38] Section 11(1) of the Act defines adequate and effective policing as requiring policing functions to be delivered in compliance with standards set out in the Act's regulations, as well as constitutional and human rights requirements:

> 11 (1) Adequate and effective policing means all of the following functions provided in accordance with the standards set out in the regulations, including the standards with respect to the avoidance of conflicts of interest, and with the requirements of the Canadian Charter of Rights and Freedoms and the Human Rights Code:
>
> 1. Crime prevention.
> 2. Law enforcement.
> 3. Maintaining the public peace.
> 4. Emergency response.
> 5. Assistance to victims of crime.
> 6. Any other prescribed policing functions.

[39] Pursuant to section 15 of the *Adequate and Effective Policing (General)* Regulation, O Reg 392/23 (the "Adequate and Effective Policing Regulation"), dispatching members of a police service is also considered a policing function that is required to be provided in an adequate and effective manner:

> 15 (1) For the purposes of paragraph 6 of subsection 11 (1) of the Act, adequate and effective policing includes dispatching members of a police service.

b) <u>Standards for adequate and effective dispatching</u>

[40] For dispatch functions in Ontario policing, there are two applicable standards: the first, specific to dispatch, and the second, a broader 'reasonableness' standard that applies to the delivery of all policing functions. In terms of the specific, the Adequate and Effective Policing Regulation contains standards that apply to dispatch, including requirements related to supervision of a police service's dispatch function:

> 15 (2) The following standards for adequate and effective policing, relating to the dispatching of members of a police service, are prescribed:

> 1. A communications centre that operates 24 hours a day with one or more communications operators or dispatchers to answer emergency calls for service and that maintains constant two-way voice communication capability with police officers who are on patrol or responding to emergency calls must be used for the purposes of dispatching members of a police service.
> 2. A member of a police service must be available 24 hours a day to supervise police communications and dispatch services.
> 3. Police officers on patrol must be provided with portable two-way voice communication capability that allows the police officers to be in contact with the communications centre when away from their vehicle or on foot patrol.
> 4. A member of a police service who supervises communications operators and dispatchers must have successfully completed the training prescribed by the Minister on that subject.
>
> [emphasis added]

[41] In terms of the broader, section 2 of the Adequate and Effective Policing Regulation requires all policing functions – including dispatch – be provided in a manner that meets the generally applicable standard of "reasonableness." What is considered reasonable is determined by considering several factors, such as the needs of the community and best practices, having regard to available qualitative and quantitative data:

> 2 (1) A policing function shall be provided to an extent and in a manner that is reasonable, having regard to the following factors:
>
> 1. The policing needs of the community.
> 2. The geographic and socio-demographic characteristics of the police service's area of policing responsibility.
> 3. The extent to and manner in which the policing function is effectively provided in similar communities in Ontario.
> 4. The extent to which past provision of the policing function by the police service has been effective in addressing the policing needs of the community.
> 5. Best practices respecting the policing function.
>
> (2) Consideration of a factor listed in subsection (1) shall be based on quantitative and qualitative information, to the extent that such information is available in relation to the factor.

[42] Reasonableness does not require perfection, but rather the delivery of a policing function that falls within a range of what may be considered appropriate. The reasonableness standard also may not result in just one appropriate outcome for what constitutes adequate and effective policing (*Findings Report INV-24-14 (Re)*, 2025 ONIOP 1, at para 22). In applying the factors to determine what "reasonableness" requires in the delivery of a policing function, there may be contexts in which a single factor (*e.g.* the policing needs of a community) is more relevant than other factors (*e.g.* best practices respecting the policing function). While I must give consideration to all relevant factors, the weight I apply to any one of them need not be the same. The concept that it is for a trier of fact to assess the relevance of factors individually and weigh them holistically when considering "reasonableness" is well-established in Canadian law (for instance, it was recently reaffirmed by the Supreme Court of Canada in *R v Khill,* 2021 SCC 37 at paras 69-70, albeit in a different context).

c) The NRPSB failed to provide adequate and effective dispatch services

[43] Based on the Findings Report, I find that the NRPSB did not comply with the Act, and more specifically, the Adequate and Effective Policing Regulation, as it relates to the delivery of "adequate and effective policing" in the dispatching of members of a police service. In my view, the reasonableness standard requires that in circumstances of a "silent call" where there is background noise that may indicate an emergency (including a safety or medical emergency) and no response from the caller, and where the NRPS automatically possesses cell phone location information, police officers should be dispatched so that they may determine whether emergency assistance is needed. Additionally, in the event a call taker is uncertain as to whether noises indicate an emergency, the call taker should be required to consult with a Supervisor to assess whether the background noise warrants police officers being dispatched before the call is cleared. In the context of this complaint, the call should not have been cleared without police officers being dispatched to the deceased's residence or, if the call taker was uncertain, a Supervisor being consulted. Of course, whether police officers attending at that time would have led to a different outcome in terms of the deceased is not something I can or should determine, and I do not do so.

i. Call takers should be required to generate a call for service in these circumstances or consult a Supervisor where background noise is ambiguous

[44] In assessing "reasonableness," I place particular weight on "[t]he policing needs of the community." The public reasonably expects that when indicators of an emergency in a 911 call are present – such as a sound of a fall and laboured breathing – an emergency response will be automatically dispatched to determine whether assistance is required. This approach recognizes that individuals typically call 911 at moments of heightened vulnerability. The system is designed and publicly understood as the mechanism to obtain urgent help. Although some responses may, in hindsight, prove unnecessary (*e.g.* the police attend and there is no need for emergency assistance), the risk associated with failing to dispatch in these circumstances is too significant and inconsistent with fundamental community policing needs.

[45] This interpretation of what the reasonable delivery of the dispatching function requires finds support in the NRPS's own assessment of this incident. After reviewing the 911 call during the Professional Standards Unit investigation, the NRPS Communication Supervisor's position was that the SOP required the call taker to initiate a call for service in the circumstances because of the presence of conspicuous noises that were more than innocent background noises (e.g. noise from traffic; people talking in the background), and the small radius known through the Automatic Location Identification. Although after-the-fact, this interpretation of the NRPS's own SOP by a Supervisor with training and experience is persuasive in terms of what a reasonable level of police service delivery through the dispatch function required in these circumstances.

[46] At the very least, in the event the call taker was uncertain about the nature of background noises present in the call, the call taker should have either entered a call for service or expeditiously reviewed the matter with a Supervisor in real-time. Background noises that may indicate an emergency could have alternative explanations. Where it is ambiguous and time may be of the essence, dispatch should be the preferred approach. Based on information gathered through this inspection, it was confirmed that this is the practice of some police services. For example, when training call takers, Durham Regional Police Service emphasizes to default to dispatch when background noises are unclear but could indicate an emergency.

[47] Alternatively, and recognizing these decisions are ultimately judgement calls that could benefit from objective expertise, a call taker should, at minimum, be required to consult with a Supervisor before clearing a call where background noises are ambiguous and cannot be determined through available means short of dispatch. In my view, the legal requirement that call-taking and dispatch functions be monitored by a Supervisor on a 24-hour basis exists for circumstances exactly like this: where a judgement call that could mean all the difference must be made. In these circumstances, there is an enhanced need to engage someone in a supervisory capacity to be a second set of eyes and ears. This helps ensure all applicable legal requirements and internal procedures are met, and a consistent approach to how these requirements are interpreted is overseen by someone at a more senior level.

[48] In summary, an application of the reasonableness standard to the NRPS's dispatch function should require that calls of this nature generate a call for service, or at least necessitate consultation and direction from the dispatch Supervisor in the event of uncertainty about the nature of background sounds before being cleared.

ii. The SOP is likely to result in the dispatch function being provided in an unreasonable manner

[49] The jurisdiction of the Inspector General of Policing may sometimes bump up against the jurisdiction of the Director of the Law Enforcement Complaints Agency, in that conduct issues can bring to light broader institutional or systems issues. While I do not address misconduct, I am empowered to consider whether failures at an institutional or organizational level prevented or are likely to prevent the delivery of adequate and effective policing. In my view, NRPS's SOP – which is institutional direction to all members – has a critical gap, leading to the NRPS's dispatching and related supervision requirements being implemented in an unreasonable manner contrary to section 2(1) of the Adequate and Effective Policing Regulation. Specifically, the current NRPS procedures related to call taking do not provide sufficient clarity or specificity about when dispatch should occur for "silent calls" originating from cell phones or embed necessary risk mitigation practices.

[50] The SOP is meant to provide clear and consistent guidance to call takers about when to enter a call for service which results in NRPS officers being dispatched. It should therefore provide essential direction to call takers about how 911 calls from cell phones are addressed when voice contact cannot be established. While the SOP provides some guidance insofar as it requires call takers to enter a call for service where there are "sounds of concern," the definition of "sounds of concern" lacks clarity. This seems to be an issue that is unique to the NRPS. From the IoP's previous inspections of other Public Safety Answering Points (call taking centres where 911 calls come in and are answered), and a jurisdictional scan of police services conducted as part of this inspection, "sounds of concern" is not a term used – rather, the focus is on the presence or absence of sounds and all of the surrounding circumstances, and whether they indicate a potential emergency. This approach minimizes the ambiguity and inconsistency that can arise when individual call takers are left to decide whether certain sounds on the other end of the line require a response, while others do not.

[51] It is not reasonable for "sounds of concern" to be left undefined in the SOP and for the NRPS to only rely on in-class training to provide examples of what does not constitute "sounds of concern." Rather, the SOP should have a clear and practically applicable definition of "sounds of concern", or an alternative threshold which would require dispatch, that makes it apparent to call takers what that concept means, so that when they encounter it, there will be minimal ambiguity and consistency in dispatch decision-making.

[52] The Toronto Police Service's 911 Call Handling Policy serves as an example of a best practice in this area insofar as it codifies precisely when dispatch should occur and provides clear guidance to call takers about how to make this assessment. Instead of focusing solely on "sounds of concern", the policy instead requires call takers to consider whether "an emergency is indicated or perceived." Further, the policy specifies the following "indications" of an emergency that call takers are to consider:

> Communications personnel shall pay close attention to background noise, tone, and word choice of callers as additional evidence to assist with determination of the status of the 9-1-1 call. The time of day and location of caller, if known, may provide additional clues to indicate whether a response is necessary.

[53] Furthermore, the NRPS's SOP does not sufficiently address when call takers are to engage a Supervisor for guidance before clearing a call. While the NRPS issued a training bulletin after this incident which stated, "When in doubt, ask a Supervisor!", this direction does not sufficiently emphasize the importance of seeking a second opinion from a Supervisor in circumstances such as those that arose in this case. This direction should instead be embedded in the NRPS's procedure to ensure it is understood as mandatory and is implemented consistently.

Issue 2: The NRPSB and NRPS Chief of Police failed to implement the required Quality Assurance processes

a) The requirement to implement Quality Assurance processes

[54] Quality assurance is a common practice implemented by organizations to drive issue identification and process improvement. In the Ontario policing context, police service boards and chiefs of police are required by law to maintain systems that monitor whether policing functions meet legislative and regulatory requirements, and constantly evaluate the delivery of policing as these requirements are defined and evolve. This requirement is contained in section 23 of the Adequate and Effective Policing Regulation:

> 23 Every police service board and every chief of police shall implement a quality assurance process relating to,
>
> (a) the provision of adequate and effective policing; and
> (b) compliance with the Act and the regulations.

[55] Analyzing the meaning of this provision is important because this is the first time it has been considered. It is well settled in Canadian law that legislative provisions are interpreted by applying the "modern approach" to statutory interpretation as articulated by the Supreme Court of Canada in *Rizzo & Rizzo Shoes Ltd. (Re)*, [1998] 1 SCR 27: "... the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament" (para 21, quoting E. A. Driedger, Construction of Statutes (2nd ed Toronto: Butterworths, 1983), at p 87).

[56] Section 23 of the Act makes implementing a Quality Assurance process a mandatory element of the adequate and effective policing framework in Ontario. However, the object and intent of this provision requires more than simply a Quality Assurance process existing on paper or being a box to check without achieving any particular substantive goal. Rather, the purpose of this provision is to ensure an overall system exists to support both police service boards and chiefs of police in carrying out their respective statutory duties. For police service boards, this is primarily the duty to ensure the delivery of adequate and effective policing established by section 10(1) of the Act. For chiefs of police, these include the duties contained in section 79 of the Act – particularly the requirement to "manage the members of the police service to ensure that they carry out their duties in accordance with this Act and the regulations."

[57] Weak or fragmented Quality Assurance practices deprive both the board and the chief of an essential early-warning system. When properly designed and applied, Quality Assurance processes help determine whether a policing function is falling below expected standards and identify what improvements – whether in governance or operations – are necessary to restore compliance with those standards. These processes serve to verify that policing functions are delivered reasonably, are supported by evidence, and align with statutory and regulatory obligations. This includes scrutiny of supervision, equipment, governance structures, training, and documented practices such as Board Policies and Chief's Procedures. In this way, Quality Assurance acts as an institutional safeguard, ensuring that the delivery of policing services meets the community's legitimate expectations and legal requirements.

[58] Quality Assurance processes implemented by police service boards and chiefs of police also must not operate in isolation. Their effectiveness depends on integration, as each entity's process informs and reinforces the other. The Adequate and Effective Policing Regulation reflects this symbiotic relationship by linking board-level policy requirements with chief of police's operational procedures; each, by design, influences the other. For a police service board to be meaningfully assured that its policy objectives are being achieved through day-to-day policing operations, it must have visibility into how those policies are being operationalized. Conversely, chiefs of police must be positioned to identify, and report to the board on, operational realities that may warrant policy refinement (Hon. John W. Morden, *Independent Civilian Review into Matters Relating to the G20 Summit* (Toronto: 2012) at pp. 7 and 85-88). A sound Quality Assurance process is a valuable mechanism through which this information is generated and can be shared. Accordingly, where a chief undertakes a Quality Assurance review, its results should be communicated to the board so the board can assess any governance implications. Likewise, boards must ensure that their own Quality

Assurance findings are shared with chiefs, so that any operationally relevant insights can be effectively considered.

b) The NRPS's after-incident review did not comply with Quality Assurance process requirements

[59] The NRPS did take some actions in response to the incident, such as a jurisdictional scan and circulation of a training bulletin; however, I do not believe these actions reflect what I have determined is required by section 23 of the Adequate and Effective Policing Regulation. Quality Assurance processes, especially in more significant cases where there is a death involved, require more.

[60] The NRPS's approach to evaluating the circumstances of how this particular call was handled and what lessons could be learned is not consistent with the approach demanded by section 23(a) of the Adequate and Effective Policing Regulation. Even if NRPS determined that there was no misconduct through its professional conduct investigation, in this case, it should have undertaken a more fulsome Quality Assurance review that focused on what may have been the contributing causes to the approach taken in this case, and whether there were broader, policy, operational and/or other issues that needed to be addressed to minimize risk and improve the delivery of adequate and effective dispatch. Put another way, the NRPS's Quality Assurance review that flowed from this case should have looked at some of the very issues I have examined in this Decision, with a view to determining how to improve. The NRPSB should have had awareness of this particular event, given its circumstances, and been engaged in the Quality Assurance process – at least insofar as NRPS's own Quality Assurance review should have been shared with the NRPSB, so that it could determine whether governance actions may also be required to improve police service delivery as it relates to dispatch. While I cannot state with certainty that this Quality Assurance process would have led to the same conclusions I have come to, not undertaking this type of examination in a case of this nature fell short of what was required.

[61] Quality Assurance processes go beyond the circumstances of individual events, and should consider the broader policy and operational environment in which policing functions are delivered. While the NRPS internal misconduct review played a role and was necessary, it did not absolve the NRPS of conducting a Quality Assurance-based review in the manner I have outlined. The results of this review should have been shared with the NRPSB so that policy dimensions could also have been considered.

V. CONCLUSION

[62] The Findings Report discloses evidence that the NRPSB and NRPS failed to comply with the legal requirements associated with an Ontario police service's call-taking and dispatch functions, as well as the requirements related to Quality Assurance processes. As well, given the current SOP, I am of the view that the Findings Report discloses evidence that "an act or omission will likely result in non-compliance," such that it is advisable that I issue a Direction to "prevent or remedy the non-compliance" pursuant to section 125(1) of the Act [emphasis added]. I also conclude that my Direction is necessary to ensure the required Quality Assurance process is in place and adhered to.

[63] In addition, while substantive matters of misconduct are not my domain, I am concerned with the way the Professional Standards Unit investigation was conducted. There was a significant lag in time between the incident and the interview of the call taker (seven weeks), and the six-minute interview of the call taker included, in my view, leading questions that may have steered the call taker to answers that were consistent with NRPS procedures. Once the call taker stated they had no recollection of this particular 911 call, this fact should have been clearly documented and reflected in the analysis, and the NRPS should have then taken additional steps to determine what occurred that evening. Instead, the NRPS's approach – of taking the position that the call taker had not heard any noises, which was contrary to the fact that the call taker had no recollection of the call – created an inconsistency that resulted in friction between NRPS and the complainant that could have been avoided.

VI. DIRECTION IMPOSED

[64] Pursuant to section 125(1) of the Act, I am permitted to issue a Direction to remedy or prevent non-compliance with the Act and its regulations:

> 125 (1) If, in the opinion of the Inspector General, the report made under subsection 123 (1) discloses evidence of non-compliance with a requirement of this Act or the regulations, or evidence that an act or omission will likely result in such non-compliance, the Inspector General may issue any directions to a police service board, O.P.P. detachment board, First Nation O.P.P. board, chief of police, special constable employer, police service or prescribed policing provider that he or she considers advisable to remedy or prevent the non-compliance.

[65] In these circumstances, I have found that the NRPSB and the NRPS (through the Chief of Police) failed to comply with section 10(1) of the Act and section 23(a) of the Adequate and Effective Policing Regulation by providing dispatch services in an unreasonable manner and by not having the required Quality Assurance process. I have found evidence that there are deficiencies in the SOP and Quality Assurances process that, if left unaddressed, will likely result in a continuation of the non-compliance.

[66] Having considered that this non-compliance was not the result of exceptional circumstances outside the NRPSB or the NRPS Chief of Police's control, I hereby exercise my authority pursuant to section 125(1) of the Act to direct the following:

1. The NRPS shall revise the SOP to ensure the following:

    a. The SOP itself include clear, unambiguous and practical guidance about what noises on silent calls will require a call taker to generate a police response.

    b. The SOP codify that, in the event of uncertainty about whether background noises indicate a potential emergency, call takers are required to either (i) treat the call as emergent or, (ii) consult with a Supervisor before clearing the call without entering a call for service and generating an emergency response.

2. The NRPS shall update its training for appropriate Communications staff to incorporate training content that reflects the revised SOP. The updated training content shall provide practical examples/case studies for how to address silent calls effectively, including those involving potential medical emergencies, and address when to engage a Supervisor.

3. The NRPSB shall update its Quality Assurance Policy and the NRPS Chief of Police shall update the NRPS's Quality Assurance Procedure to provide policy and operational governance concerning the need for after-action reviews for matters related to the improvement of the delivery of policing functions, and specifying the criteria to determine when such reviews are required, the reporting that must be generated, and the engagement between the NRPSB and the NRPS Chief of Police following such a review.

4. The NRPSB shall require the NRPS Chief of Police to report back to the NRPSB concerning the implementation of this Direction, including details concerning specific improvements made, how implementation is being monitored, and identify areas where potential improvements to Board Policy or governance may be required in order to give effect to this Direction.

5. The NRPSB and NRPS Chief of Police shall provide status updates about the implementation of requirements 1 to 4 of this Direction to me, in writing, upon request.

6. The NRPSB and NRPS Chief of Police shall confirm it has implemented requirements 1 to 4 of this Direction to me in writing within 90 days of this Direction. This confirmation shall include copies of any policies, procedures or training documents that were updated because of this Direction.

Date: July 30, 2026

Original Signed By

_____

Ryan Teschner
Inspector General of Policing

Inspectorate of Policing

FINDINGS REPORT

Niagara Regional Police Service

Section 107(1)(a) Policing Complaint Investigation
(INV-24-46)

Submitted to:
Ryan Teschner
Inspector General of Policing of Ontario

February 19, 2026

TABLE OF CONTENTS

ABOUT THE INSPECTOR GENERAL OF POLICING AND THE INSPECTORATE OF POLICING

The Inspector General of Policing drives improved performance and accountability in policing and police governance by overseeing the delivery of adequate and effective policing across Ontario. The Inspector General ensures compliance with the province's policing legislation and standards, and has the authority to issue progressive, risk-based and binding directions and measures to protect public safety. Ontario's Community Safety and Policing Act embeds protections to ensure the Inspector General's statutory duty is delivered independently from government.

The Inspector General of Policing leads the Inspectorate of Policing (IoP). The IoP provides operational support to inspect, investigate, monitor, and advise Ontario's police services, boards and special constable employers. By leveraging independent research and data intelligence, the IoP promotes leading practices and identifies areas for improvement, ensuring that high-quality policing and police governance is delivered to make everyone in Ontario safer.

In March 2023, Ryan Teschner was appointed as Ontario's first Inspector General of Policing with duties and authorities under the Community Safety and Policing Act. Mr. Teschner is a recognized expert in public administration, policing and police governance.

For more information about the Inspector General of Policing or the IoP, please visit www.iopontario.ca.

INTRODUCTION

This is a report to the Inspector General of Policing by an inspector appointed by the Inspector General, who has completed an investigation under Part VII of the *Community Safety and Policing Act, 2019* (CSPA).

OVERVIEW OF INVESTIGATION

The Complaint

A written complaint was forwarded by the Law Enforcement Complaints Agency (LECA) to the Inspector General under the provisions of section 108 of the CSPA. The complaint alleged that the Niagara Regional Police Service (NRPS) had failed to dispatch officers to a 911 cellular call in the middle of the night. The caller was found dead hours later by his adult daughter. The last number called on the decedent's phone was the 911 call.

The Subject Police Service

Name of Police Service: Niagara Regional Police Service
Service Headquarters: 5700 Valley Way, Niagara Falls, Ontario, L2E 1X8
Chief of Police: Bill Fordy
Chief of Police since June 27, 2017
Service Total Strength: (Actual & Authorized)

- Number of sworn members:
  Actual: 842
  Authorized: 819
- Number of civilian members:
  Actual: 343
  Authorized: 348

Geographic Service Area

- 1854 Square Kilometers
- Community Population of approximately 539,180

Applicable Legislative and Regulatory Provisions

Section 11(1) of the CSPA provides that adequate and effective policing means all of the following functions provided in accordance with the standards set out in the regulations, including the standards with respect to the avoidance of conflicts of interest, and with the requirements of the *Canadian Charter of Rights and Freedoms* and the *Human Rights Code*:

1. Crime prevention.
2. Law enforcement.
3. Maintaining the public peace.
4. Emergency response.
5. Assistance to victims of crime.
6. Any other prescribed policing functions.

Ontario Regulation 392/23: ADEQUATE AND EFFECTIVE POLICING (GENERAL) was reviewed having regard to the allegations made in the complaint.

Dispatching

15. (1) For the purposes of paragraph 6 of subsection 11 (1) of the Act, adequate and effective policing includes dispatching members of a police service.

(2) The following standards for adequate and effective policing, relating to the dispatching of members of a police service, are prescribed:

1. A communications centre that operates 24 hours a day with one or more communications operators or dispatchers to answer emergency calls for service and that maintains constant two-way voice communication capability with police officers who are on patrol or responding to emergency calls must be used for the purposes of dispatching members of a police service.
2. A member of a police service must be available 24 hours a day to supervise police communications and dispatch services.
3. Police officers on patrol must be provided with portable two-way voice communication capability that allows the police officers to be in contact with the communications centre when away from their vehicle or on foot patrol.
4. A member of a police service who supervises communications operators and dispatchers must have successfully completed the training prescribed by the Minister on that subject.

(3) Every chief of police shall establish written procedures on communications and dispatch services.

Ontario Regulation 87/24: Training touches upon the issue of dispatching only once, in relation to supervision, requiring that:

Supervision of communications centre

21. … every police officer whose assigned responsibilities include directly supervising communications operators and dispatchers shall, no later than 12 months after being assigned this responsibility, successfully complete the course entitled “Communications Centre Supervisor”, delivered by the College or by a certified trainer in respect of the course.

SUMMARY OF THE INVESTIGATION CONDUCTED

This investigation included several interviews with the complainant, as well as a review of, amongst other records:

- the NRPS Professional Standards Unit Investigation Report;
- internal NRPS emails, briefing notes and related correspondence;
- NRPS dispatch and related data and occurrence reports;
- the audio-recording of the 911 call made by the decedent on August 30, 2024;
- audio-recordings made by the complainant of conversations with NRPS investigators and command staff;
- relevant NRPS policies and procedures and training materials; and
- the applicable legislative provisions.

The Complaint

The Initial Complaint to LECA

The original complaint was filed with LECA on October 7, 2024 and read:

> My brother [*name redacted*] called 911 on Aug 30th at 2:56 am EST and the duration of the call lasted 36 seconds. No one had attended his home in response to his call for help. He was then found dead at 8am that morning. As per [*a Detective Sergeant*]'s investigation into this matter, he advises us of the following: the call was deemed a silent call (No response from [*the decedent*] when 911 identified themselves). The 911 dispatcher heard what they deem to be a drop and then something that sounded like wind- exhaling of breath. The dispatcher attempted to call back but there was no answer. They then did a drop search to determine the location which they then determined that the call came within a 41meter radius. [*Decedent's home address*] was in the center of that radius, as stated by [*the Detective Sergeant*]. [*The Detective Sergeant*] stated that no one was sent to the house and is unsure why and an internal investigation was underway. He said that they made a mistake.

LECA determined that the complaint raised issues that fell within the mandate by the Inspector General of Policing and forwarded the complaint accordingly.

The Complainant Interviews with IoP

The complainant resides outside of Canada. He was interviewed several times by telephone and videoconference calls, as well as supplying information and various records by email. The following is a summary of his evidence.

The complainant was the brother of the decedent, who lived in a suburban home with his family on the outskirts of Welland, Ontario. [This neighbourhood falls within the region policed by the NRPS, which is also responsible for the attendant 911 and dispatch services.]

On August 30, 2024, the complainant was visiting with his brother and family at his brother's home. At approximately 8 a.m., the complainant was awakened by his niece. She had discovered the decedent lying face down in the kitchen, his right arm extended and a cell phone laying near his hand. The complainant rolled the body over and began chest compressions. The niece called 911 for an ambulance.

When the paramedics arrived, the decedent was pronounced dead. The complainant believed that the decedent's cell phone still lay on the floor near his body.

The police arrived shortly afterward. They photographed the scene and inspected the garage area.

Later that day, after the police and paramedics had departed, the complainant and his sister – who had arrived in the meantime – retrieved the decedent's cellphone and handed it over to the decedent's business partner, who was the executor of the decedent's estate.

On September 1, the executor contacted the complainant's sister to notify her of the discovery of the 911 call on the decedent's cellphone. The executor on that date also contacted the NRPS and spoke with a detective to report the discovery.

The NRPS detective later told the complainant's sister that he had listened to the audio and heard a thump, followed by wheezing and exhaling. The 911 dispatcher had reportedly heard no verbal response to her questions, attempted a callback, pinged the phone to a 41-metre radius, and confirmed no prior 911 calls from the number. Despite all of this, no officers were dispatched. The detective acknowledged an internal investigation had begun and referred to the situation as a "mistake".

On September 4, 2024, the complainant met with a NRPS Inspector, who admitted the situation was a “screwup” and promised a full investigation in which he would “hold nothing back from them”. The Inspector also suggested that the complainant consider finding “a good civil lawyer”. The complainant did not, as he believed that the inspector would provide him with the honest answers as to why no one responded to the 911 call.

Over the next several weeks, the complainant followed up with the Inspector, who told the complainant that it was proving difficult to interview the call-taker because she was “on holidays”. The complainant began to wonder what was going on.

At the beginning of October 2024, the complainant also spoke with the Coroner’s Office, who confirmed that the decedent had been in excellent health. The coroner told him that 20% of heart attack victims survive with timely intervention, and the decedent likely fell within that group. As of their last conversation, the coroner had still not received the audio of the 911 call and was waiting to review it before closing the case.

On October 7, 2024, the complainant filed a public complaint with LECA. (That complaint was subsequently forwarded to this office for assessment and investigation.)

On October 28, 2024, the Inspector called the complainant by telephone. The complainant recorded the conversation. The Inspector told the complainant that the internal investigation was now complete. The investigation determined that there was no misconduct on the part of the call-taker that received the decedent’s 911 call, as she did not hear anything that caused her concern.

This made the complainant suspicious of a “cover-up” because the original investigating officer had previously told them that he had listened to the 911 audio and heard the sound of something dropping and what he thought were sounds of breathing.

The complainant’s sister called the original investigating officer the next day. She recorded the conversation. The investigating officer confirmed that he had indeed heard the noises on the 911 audio, but the complainant felt that the detective was trying to make excuses for the 911 call-taker and using phrases like “in hindsight”.

In the autumn of 2024 and the spring of 2025, the complainant’s sister filed several freedom of information requests on behalf of the family with the NRPS, trying to get copies of records such as the 911 call made by the decedent and the internal NRPS investigative report. His sister was repeatedly refused the records for a long list of reasons. She became increasingly upset and would be in tears when she called him.

She subsequently launched an appeal with the Information and Privacy Commissioner ("IPC").

On March 13, 2025, the complainant's sister received a letter "out of the blue" from the NPRS, partially amending its earlier decision and attaching a heavily redacted copy of the sudden death occurrence report from the morning of August 30, 2024.

In May 2025, the complainant engaged the IPC-assigned mediator several times in an attempt to secure the original records. The NRPS continued to refuse to release the records.

NRPS Briefing Notes on Incident 24-97053

The first in a series of internal NRPS briefing notes about the incident, dating from September 2, 2024, reveals the information initially known to the NRPS.

The note confirms that the NRPS was contacted by the complainant's family to ascertain if a call was placed to 911 on August 30, 2024 from the decedent's cell phone prior to his death. It explains that the decedent's cell phone call history showed such a call.

A subsequent search of the 911 dispatch logs revealed the call by the decedent at 2:56 a.m. The call was received and answered by the call-taker and lasted approximately 36 seconds. The note states that the call-taker called the number back, there was no answer, and it was cleared as a "silent call" with no call for service generated. It explains that the 911 information mapping identified the location of the decedent's cellphone at the time of the call within a radius of 41 metres, with the centre of the radius directly over the decedent's home address.

The note closes with the observation of the Communications Supervisor:

> Call for service should have been generated following the 911 SOP Sec 5.1.2 due to the small radius of the 911 drop and background noise heard.

By an internal memorandum, dated September 4, 2024, Acting Chief of Police Waselovich approved a Professional Standards investigation into the circumstances.

NRPS Professional Standards Unit Investigation Report

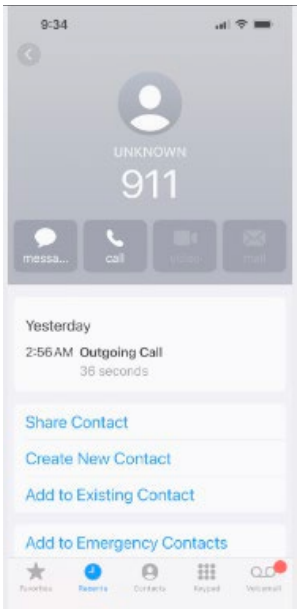
The professional standards investigation report ("PSU Report") is summarised in a 13-page report that examined the circumstances surrounding the decedent's 911 call. Its express focus was, however, to determine whether the call-taker had committed

“misconduct” in failing to comply with the provisions of the NRPS *Standard Operating Procedure* governing 911 calls.

The investigator reviewed the audio recording of the 911 call, describing it thus:

- The audio clip is 37 seconds in duration and commences with [name redacted] stating, *Niagara Emergency, do you need police, fire or ambulance?*
- At the 4 second mark it sounds as if someone has dropped something or may had fallen down.
- At the 14 second mark, laboured breathing is evident in the background, although it is faint, and becomes more apparent at the 20 second mark at which point [name redacted] can be heard saying, *can you hear me?*
- From 23 seconds to 36 seconds deep breathing is obvious and congested and sounds like snoring.
- The call is disconnected at 36 seconds while breathing is still evident.

The Report then canvassed the circumstances surrounding the discovery of the decedent the following morning, the subsequent sudden death investigation, and the discovery of the decedent’s prior 911 to NRPS. The Report closed with a summary of an interview with the call-taker and compared the call-taker’s actions with the NRPS operating procedures.



[Screen shot of decedent’s cell phone taken by business partner: *NRPS Report*.]

It concluded that:

- the decedent's phone "was not accessible during the time the police were on scene";
- the call-taker did not recall the 911 call in question;
- the call-taker classified the 911 call as a *silent call* despite the audio revealing "sounds to cause concerns" – *i.e.* sounds that suggested the caller may have fallen and was having difficulty breathing;
- the call-taker was aware that cellphones can be *pinged* but the threshold is high and more than background noise is required for such a request;
- there was information available pertaining to the location and origin of the call that was not investigated;
- the call should not have been cleared until it has been established that the caller didn't require any assistance by using all measures necessary;
- there was no evidence that the call-taker acted with "malice or intent", and
- accordingly, the allegation of misconduct was unsubstantiated.

Curiously, the Report's analysis relied on "mitigating" factors such as the other parties in the decedent's home failing to respond to 911 callback on the decedent's phone, while asserting that the call-taker had not heard anything to cause concern.

The PSU Report did not address the issue of "mistake" and the distance between *mistake* and *misconduct*.

NRPS 911 System

The NRPS Communications Unit acts as the Primary Public Safety Answering Point ("PPSAP") for emergency calls to police, fire and ambulance in the Niagara Region. It employs an Enhanced 911 ("E911") system that has been in place for over 20 years.

When a cellphone calls E911, the NRPS generates a host of information for a call-taker that includes: the device's telephone number; service provider's name; the latitude and longitude of the device based on signal triangulation by cell towers, including a radius of uncertainty; local cell tower location; and secondary PSAP information (such as phone numbers for local police, fire and ambulance) based on the location.

The telephone number of the device is information included in the data component of the incoming phone call. The location information – for cellphones, known as a *drop* – is generated separately for each call using data that accompanies the incoming call as well as queries of associated databases. Together, these capabilities are known as "Automatic Number Identification" and "Automatic Location Identification", or ANI/ALI.

In situations involving imminent danger or risk to life, 911 operators have the additional ability to complete a *query* on the cellphone that potentially reveals additional information related to the caller. A cellphone *query* generates information such as the frequency of calls to the PSAP from the phone number, and any previous calls or names associated with the number.

Finally, 911 operators can contact the cellphone provider to request subscriber information and to *ping* a cellphone for updated location information. (A *drop* provides preliminary location information when the call is received and is generated by the E911 system automatically. A *ping* is a separate manual action, which requires the cooperation of the cell provider, to deliver a more precise or up-to-date location for the cellphone.)

August 30, 2024: The Decedent's 911 Call

This investigation reviewed the audio recording of the 911 call and examined the ANI/ALI record of the decedent's call to 911 on August 30, 2024 at 2:56 a.m.

Upon receiving the decedent's 911 call, the NRPS E911 system provided the call-taker with the decedent's cellphone number, his cellphone provider, and the location of his cellphone (*i.e.* the *drop*) within a 41-metre radius, with the centre of that circle being directly over his home address.

The NRPS records confirm that the call-taker did not *ping* the phone, as it did not appear to meet the required threshold.

The NRPS Briefing Note, previously discussed, did however confirm that the call-taker had conducted a cellphone *query* that revealed that this was the first time the phone had called 911.

The transcript of the call provided in the PSU report is an accurate representation of what is said and the sounds that can be heard on the audio recording of the 911 call.

The call-taker subsequently cleared the call as a *silent call* and did not generate a call for service.

The complainant confirmed, after reviewing the decedent's phone, that a call from an unknown number was received shortly after the 911 call. This may have been the NRPS callback; however, no voicemail was left.

NRPS advise that the only available record is the outgoing 911 callback made by the call taker. While the recording system captured that an outgoing call occurred, it does not contain any associated data identifying the number that was dialled.

The Sudden Death Investigation – Incident 2024-97053

The NRPS dispatch records confirm that at 8:06 a.m. that same morning, the NRPS received a 911 from the decedent's daughter advising that she had found her father with no apparent vital signs. At 8:08 a.m., the NRPS received a call from the ambulance service requesting police attendance at the decedent's home address.

At 8:23 a.m., the first NRPS officer arrived at the scene. The subsequent sudden death investigation was assigned to an NRPS investigator, and the scene photographed by a forensics officer with the decedent still *in situ*. The first general occurrence report, dated August 30, 2024 and authored by the uniform officer first on scene provides details of the call's history, the kitchen scene where the decedent was found, the decedent's medical history and a brief description of the events leading to the 911 call by the daughter. There is no mention of the decedent's cellphone or his call to 911 at 2:56 a.m.

The Forensics Unit report, dated August 31, 2024 and authored by the attending forensics officer, describes the circumstances surrounding the discovery of the decedent and the scene in greater detail, as well as providing details of the attending coroner and anticipated autopsy. There is no mention of the decedent's cellphone.

The Forensics Unit photographs portray the kitchen scene as it appeared after lifesaving efforts by the family stopped and the paramedics attended, and before the decedent's body was moved further. The photos depict a kitchen table approximately 2 metres from the decedent's body. Of note, the photos clearly depict two cellphones, a pair of glasses, and the decedent's Ontario Health card on the kitchen table.

The investigating officer's supplementary report, dated September 1, 2025, reports some background information relating to the decedent and summaries of on-scene interviews with the complainant, the complainant's wife, and the decedent's daughter. Each described finding the decedent and the steps they took after finding him and calling 911. There is no mention of the decedent's cellphone.

A review of the interview recordings confirmed that none of the decedent's family members mentioned finding the decedent's cellphone on the kitchen floor in their descriptions of what they saw when they found the decedent.

An addendum to the report details the call that day by the decedent's business partner to the investigating officer, wherein the NRPS learned of the decedent's call to 911 at 2:56 a.m. when the business partner was perusing the decedent's cellphone call history. The business partner provided the investigating officer with a screen shot of the 911 call. Curiously, the investigating officer states that the decedent's phone "was not accessible during the time the police were on scene", without providing any explanation or reference.

The subsequent post-mortem examination reported that the decedent died of atherosclerotic heart disease. The toxicology analysis revealed no alcohol or drugs.

NRPS Policy and Training

National Emergency Number Association (NENA)

NENA is a not-for-profit corporation established in 1982 to further the goal of "One Nation-One Number". It is a networking source and promotes research, planning and training. NENA strives to educate, set standards and provide certification programs, legislative representation and technical assistance for implementing and managing 911 systems.

NENA standards for 911 response are generally considered "best practices", and the NRPS communications procedures incorporate many of those standards.

Standard Operating Procedures

The procedures for addressing *silent calls* from a cellphone received by the 911 call-takers are governed by the NRPS Communications Unit Standard Operating Procedure OP-003 (eff. 2021-12-03) ("SOP").

Subsection 3.17 of the SOP defines *silent 9-1-1* as:

> When 9-1-1 has been dialed and successfully passed through the 9-1-1 Dedicated Network and answered by a 9-1-1 operator yet no voice communication is made. There may be silence on the line or the Call Taker can hear a disturbance and unable to make voice contact with the caller.

Subsection 4.0 establishes the overall procedures for answering 911 calls, incorporating many elements of the NENA standards. For example, subsection 4.2.2 addresses the possibility of a caller who is deaf or mute and prescribes that:

> 4.2.2. All silent voice calls shall be interrogated with a TTY/TDD to determine if the caller is attempting to report an emergency using a special communications device for the deaf, hard of hearing, or speech impaired individuals.

Call takers responsibilities are identified in section 5 of the SOP. *Silent cell* calls are addressed specifically in subsection 5.2.2:

> A silent cell call shall not be cleared until it has been established that the caller doesn't require any assistance by using all measures necessary.
>
> It is important to note that any silent call could be an indicator of a call being placed by a deaf, hard of hearing or speech impaired person. Agent511 shall be considered as a means of making contact with the caller.
>
> When unable to establish voice contact but there are sounds to cause concern, the Call Taker shall:
>
> > i. Keep the cell line open for as long as possible
> > ii. Use the Geo-code (LAT / LONG) information and phone number from the ANI/ALI to enter a call for service. Make note of the Radius of uncertainty. If GPS coordinates are not available, the cell tower location displayed on the ANI/ALI shall be used as the Incident location
> > iii. Use the In Call Logged Unit (ICLU) CAD command to determine whether the caller is moving
> > iv. Notation shall be made in the CAD call that the location cannot be verified due to no voice contact. Police Priority Dispatch System (PPDS) does not need to be utilized unless voice contact is made. At that time, commence PPDS Case Entry questions
> > v. Complete a query on the cell phone number in an attempt to obtain potential information related to the caller. Note frequency of calls from the cell phone, any previous calls and names associated with the number. Complete queries on any name or address obtained when warranted, call the appropriate cell provider in order to obtain subscriber information which could assist in locating the caller

vi. When warranted, contact the appropriate cell provider and request a “ping” on the cell number. Document the Request ID in the CAD incident to assist in any further “ping” requests

[Redacted – s 1(1)1 – O Reg 317/24]

The terms “all measures necessary” and “sounds of concern” are not defined in the SOP.

[Redacted – s 1(1)1 – O Reg 317/24]

According to NRPS SOPS, when a 9-1-1 call from a residential or institutional landline is abandoned or disconnected, the call taker is required to ring back the number before generating a call for service; if voice contact is made, the call taker must identify themselves, confirm whether the call was intentional, and determine the required emergency service. Where no voice contact is established, the attempt is documented in the CAD and the call proceeds as a Priority 2 response. In situations where background disturbance is heard, the call taker must remain on the line or continue ringing back to capture any further information, disconnecting only once police have arrived unless maintaining contact is necessary to assist officers in reaching the caller. The decedent’s 911 call bore location information from a residential area with a radius of 41 metres.

NRPS Communications Training

The core competencies for the position of “police communicator” – known as a “call taker” in this investigation – are established by the Public Safety Division of the Ministry of the Solicitor General. They flow from the statutory requirements provided in the CSPA and the *Adequate and Effective Policing (General)* regulation, O Reg 392/23.

As is customary in Ontario, the NRPS are responsible for training of police communicators. The NRPS report that they deliver the initial training in a classroom setting with lectures and practical exercises. Members of specialized units (*e.g.* domestic violence investigators and tactical officers) will deliver some specific training, but the majority of the training is delivered by qualified training coordinators.

The classroom training is two weeks long, followed by one week of scenario training. Thereafter, the trainee is moved to the communications unit and paired with a trainer where they take live calls. The trainee is continuously monitored and receives feedback. This live training portion lasts for several weeks.

The SOP for call taking and 911 calls is addressed during the classroom training component. Although the term “sounds of concern” is not defined in the SOP, the training addresses the issue by canvassing sounds that typically do not cause concern – *e.g.* traffic noise, conversational talking to another individual, scraping sound of cellphone in pocket.

NRPS Policy Response

As of May 2025, the NRPS reported that the following steps were taken to ensure compliance with the CSPA and its regulations:

i) a *silent cell* 911 training bulletin was circulated to every member of the Communications Unit;
ii) communications supervisors reviewed the *silent cell* process with members of their platoons;
iii) the SOP was reviewed to ensure the processes still aligned with current technologies;
iv) an “environmental scan” was conducted through the training network of PSAP’s in Ontario; and
v) consequently, no changes were made to the SOP as no deficiencies were identified.

This investigation reviewed the *silent cell* training bulletin that was circulated. Dated September 4, 2024, the bulletin, entitled *Silent 9-1-1 Cell: Call Handling Procedure*, included the definition of *silent cell* from subsection 3.17 and a word-for-word recitation of subsection 5.2.2 of the SOP, with one exception.

The final sentence of the bulletin, not found in the SOP, reads:

> When in doubt, ask a Supervisor! They can play the call back and help you determine if there are any unconfirmed background noises, sounds of a struggle, etc.

This exhortation does not appear in the SOP protocols for *silent cells*.

The environmental scan started as an email, sent on January 9, 2025, that requested other Ontario PSAP's to share their protocols for cellphone calls to 911 where no voice contact could be established. NRPS provided a summary of responses from PSAP's in York Region, Windsor, Thunder Bay, Ottawa and Waterloo Region. It is not known if other PSAP's responded. The summary of protocols provided included minor variations, but all incorporated clearing a 911 cellphone call with no call for service where no voice contact is established.

IoP Jurisdictional Scan

The IoP canvassed how other police services respond to *silent calls*, including the Durham Regional Police Service, Halton Regional Police Service, Hamilton Police Service, Peel Regional Police and Toronto Police Service. None of the police services use the term "sounds of concern." Instead, call takers are required to listen for the presence or absence of background noises that might indicate an emergency.

The following services' approach to call taking and dispatch are particularly instructive.

Toronto Police Service

The Toronto Police Service's 911 Call Handling Policy was reviewed. [Redacted – s 1(1)1 – O Reg 317/24]

The policy provides the following guidance on "indications" of an emergency:

> Communications personnel shall pay close attention to background noise, tone, and word choice of callers as additional evidence to assist with determination of the status of the 9-1-1 call. The time of day and location of caller, if known, may provide additional clues to indicate whether a response is necessary.

Durham Regional Police Service

The Durham Regional Police Service's Call Taking and Dispatch SOP was reviewed and communications training staff were consulted. The SOP indicates that where there is a call with no voice contact from a cellphone, the call taker will listen and process based on whether background noise is "emergent", "non emergent but inconclusive (undeterminable)" or "suggests a clear accidental call".

[Redacted – s 1(1)1 – O Reg 317/24]

The SOP does not contain specific examples of what background noise is considered emergent or non emergent but inconclusive, and this is left to the discretion of the call taker. However, call takers are trained to dispatch in circumstances which may be emergent but have other explanations. An example used in training is that the sound of running might indicate someone is on a jog, but it could also mean someone is running for their lives. Similarly, relatively innocuous sounds, such as the sound of a TV, may be considered non emergent but inconclusive, requiring the call taker to make attempts at contact.

[Redacted – s 1(1)1 – O Reg 317/24]

The SOP also notes that call takers are to "ALWAYS" consult a supervisor if they are unsure.

The Complainant's Subsequent Interaction with the NRPS

The Initial Complaint to LECA

As previously discussed, the complainant filed a complaint with LECA on October 7, 2024.

Call 1 with the NRPS Inspector

On October 26, 2024, the complainant received a telephone call from a NRPS inspector.

The inspector informed the complainant that the internal NRPS investigation was almost completed, and the final report was "going through the chain of command". The complainant informed the inspector that he would be leaving Canada in two days' time. The inspector promised to contact him (or his sister) as soon as the inspector received the final conclusions.

Call 2 with the NRPS Inspector

On October 28, 2024, the complainant received a follow-up telephone call from the same NRPS inspector.

During the approximately 7-minute call, the inspector reported to the complainant that the internal NRPS investigation was complete and it had been determined that there was “no misconduct on the part of the [call taker] that took the [the decedent’s 911] call”. He also reported that the call taker “did not hear any sounds or noises on the call that would cause [the call taker] concern”. He confirmed that the call taker also called the complainant’s brother back, but got no answer. The call taker presumed it was a dropped call.

The complainant replied that this information conflicted with what the investigating officers had told them that was heard. The complainant requested to review recordings of the call taker’s interview and the professional standards investigation, asserting that the inspector had promised that the NRPS would not “try to hide anything” when they first met.

The inspector told the complainant that he understood that the complainant had already filed a complaint, and would have to get the NRPS records he wanted through the “complaint process”.

The Call with the NRPS Detective Sergeant

On October 29, 2024, the complainant’s sister called the detective who had been responsible for the original sudden death investigation.

In the approximately 10-minute call, the detective confirmed that he had heard sounds on the 911 recording that, in hindsight, sounded to him like banging and breath sounds. The detective did not know what the call taker had, or had not, heard at the time, given her headset and the communications room environment. He had no details beyond knowing that there was an investigation, the call taker was interviewed, and the conclusion reached that the call taker did not violate any NRPS policies.

The complainant’s sister and the detective discussed the policies governing responses to 911 calls. She concluded by confirming that the detective had indeed heard what he told them in the days after the death of her brother.

Freedom of Information Requests

Starting in November 2024, the complainant’s sister made a number of requests for NRPS records pursuant to the *Municipal Freedom of Information and Protection of Privacy Act* (“MFIPPA”). It is beyond the remit of this investigation to resolve all of the issues attending the requests – those more properly fall within the purview of the

Information and Privacy Commissioner (“IPC”). Nevertheless, a brief survey of what happened provides some context to the overall response of the NRPS.

On November 13, 2024, the complainant reports that his sister filed a freedom of information (“FOI’) request with the NRPS for the release of a copy of the 911 call, the NRPS policies for *silent calls* to 911, and the PSU Report of the 911 call.

On November 22, 2024, the complainant reports that his sister received a response from the NRPS, denying release of the records on 9 grounds drawn from MFIPPA.

On January 14, 2025, the complainant’s sister received a telephone call from the original investigating detective, informing her that he was formally closing the sudden death investigation. She asked if that was the reason the FOI request was denied. He did not know, but suggested that if she was going to file another FOI request that she consider waiting several days.

On January 28, 2025, the complainant’s sister filed a second FOI request for the same three items from the NRPS.

On February 14, 2025, the NRPS replied by letter, denying the request on the grounds that “this case is currently under investigation”.

On March 4, 2025, the NRPS informed the complainant’s sister that it was partially amending its earlier position and attaching a heavily redacted copy of the sudden death occurrence report from the morning of August 30, 2024.

In May 2025, the complainant reports that he and his sister engaged the IPC-assigned mediator several times in an attempt to secure the records from the original records. He reports that the NRPS continued to refuse to release the records.

The MPP’s Involvement

On June 12, 2025, the complainant and his sister met with the Member for Provincial Parliament (Welland), Jeff Burch to discuss their frustrations with the NRPS response. The complainant was aware that MPP Burch subsequently sent a letter to NRPS Chief of Police Bill Fordy, outlining their concerns.

On July 10, 2025, the complainant received a copy of the 911 audio recording.

The Chief's Involvement

On July 17, 2025, NRPS Chief Fordy wrote the complainant and his sister to apologise, express his condolences, and acknowledge "that the way the emergency call was managed was due, in part, to an error in process." He admitted that the NRPS had failed to recognize or respond to the immediate needs of the family and offered to meet with the family and discuss any remaining concerns. A meeting was subsequently scheduled for Friday, July 25, 2025.

On July 22, 2025, Chief Fordy telephoned the complainant from his car in response to a message from the complainant the day before. The complainant recorded the 4.5-minute conversation. The Chief expressed his desire to share the NRPS records with the complainant and his sister at their upcoming meeting on July 25. However, the Chief insisted that he could not have those records released "onto the Internet".

Consequently, he wanted to send the complainant and his sister an undertaking to keep the records confidential for them to sign ahead of time, so as "not to surprise them". The Chief explained that his offer to the family was "not normally what happens" – information was "normally shared through lawyers or through legal processes". The Chief suggested that the complainant have a lawyer review the undertaking, and offered to pay for the complainant's legal fees when he revealed that he did not have a lawyer.

On July 23, 2025, Chief Fordy and Deputy Chief Lou Greco spoke by telephone with the complainant and his sister. The complainant recorded the approximately 33-minute conversation. Chief Fordy reiterated that his offer to share NRPS records with them was not the "normal process" – in fact, he had overruled his own "records people". But because of what the family had been through, the Chief did not want them to have to wait. The complainant and his sister asked whether other family members or close friends might have to sign the undertaking if they wanted to see "the report". The Chief wished to restrict the sharing of these records to immediate family, and admitted that there might be civil liabilities flowing from a breach of the undertaking.

They then canvassed the types of records the Chief anticipating sharing with them on Friday. Chief Fordy explained that sometimes a "disconnect" developed in the police response, because of the different "silos" in the NRPS that had become engaged in this matter – for example, the professional standards unit was dealing with the Inspectorate of Policing and the records department was dealing with the FOI requests, and they don't connect with each other.

The Chief admitted that he became engaged when he received the letter from MPP Burch and he said, “Let’s acknowledge there’s … a mistake here”. He acknowledged that the struggle for his organisation was distinguishing between “mistake” and “misconduct”.

The complainant explained that if the NRPS had simply admitted its mistake at the beginning – instead of the inspector calling to tell them that the call taker had heard nothing on the 911 call - then the complainant would not have pursued the matter and had to go through this for the past 10 months.

Ultimately, the complainant and his sister preferred to have the meeting without signing the undertaking. In turn, the Chief agreed to meet with them to discuss the internal investigation, NRPS policies, and what changes the NRPS had instituted, but without sharing the documents themselves.

On July 25, 2025, Chief Fordy, Deputy Chief L. Greco, and Deputy Chief T. Waselovich met with the complainant and his two sisters at the NRPS headquarters. The complainant and his sister recorded the over 2-hour discussion.

The parties reviewed the issues and NRPS response that had led to the meeting. The complainant spoke about his experiences and the impact on him and his family for the past many months, and his appreciation for the Chief’s decision to meet with them and share the NRPS’ findings. The Chief and deputies reviewed the protocols for 911 calls, and the fact that because the call taker did not hear anything, none of police, fire or ambulance were dispatched. The complainant argued that his brother’s 911 call should have been classified as a *non-responsive* or *unknown* call that would have precipitated a response.

There followed considerable discussion about how or why the call taker had not heard the sounds made by the decedent on his call to 911. One of the deputy chiefs confirmed that the PSU investigators had heard the sounds on the 911 call, just as the sudden death investigator had. However, he asserted that with “100% certainty, from the report, when they interviewed [the call taker], the [call taker]’s acknowledging [the call taker] didn’t hear any sounds.” The deputy chief explained that the communications call takers do not use noise-cancelling headsets. Instead, their headsets have only one earpiece, so that the call takers can speak with each other within the dispatch unit as their duties require. The environment can, as a result, become quite noisy.

In answer to the complainant asking what changes had been made, the NRPS command staff advised that no NRPS policy changes had been required, but the training and policies had been revisited and reinforced with communications staff. They explained that the call takers cannot use double-ear headsets or noise-cancelling headsets because they need to communicate with each other in the event of emergency calls. The NRPS were, however, working with NENA and reviewing upgraded headsets, updates to the 911 system using artificial intelligence that would help identify sounds on 911 calls, and instituting hearing testing for call takers. Additionally, the NRPS had recently implemented the Rapid SOS technology, which could provide precise GPS locations for cellphones calling 911.

At the meeting's conclusion, the family and command staff discussed the specific issues that caused the family's angst and the "right thing to do". The complainant reports that Deputy Chief Greco agreed that "this meeting was the right thing", but that the Deputy Chief continued:

> …I'm not saying this to be an excuse or a reason to lie, often times when things escalate that, when you're a young police officer, you're told cover your ass, cover your ass, do everything to cover your ass, to make sure you don't bring liability and exposure to the organization, and sometimes that mentality sticks. When things escalate to a point where it's going to be external oversight bodies, it's let the processes take their course, let those investigations happen and don't commit that you did this or you did that. There was a mistake made, 100 % there was a mistake made, but often people of lower ranks don't feel they have the ability to come right out and say that, are you creating liability on the organization, creating liability on the Chief. Am I going to get in trouble from my superiors because I said that we made a mistake, and I'm not saying that, I don't know if that's what was happening in [the Inspector]*'s* mind at this point but a lot of times, when again because I was in the Professional Standards, with the SIU, this wait till you get a chance to speak to your union rep, wait till you get a chance to speak to a lawyer, don't make comments that your committing that the organization made a mistake. I'm not saying it's the right mentality, but that sometimes is the mentality that's out there where people are being non-committal on, that a mistake was made.

The complainant filed a subsequent complaint with the IoP in respect of the deputy's comments.

INVESTIGATION FINDINGS

I make the following findings, relying on the material and information collected during the investigation and now contained in this report:

1. **The decedent's 911 call should not have been cleared as a *silent cell* and should have generated a NRPS response.**

    a. This conclusion was identified immediately upon the discovery of the decedent's 911 call by the original NRPS detective and the communications supervisor.

    b. The communications supervisor first tasked with the review of the 911 call observed (as quoted in the first NRPS Briefing Note): *Call for service should have been generated following the 911 SOP Sec 5.1.2 due to the small radius of the 911 drop and background noise heard.*

    c. The original investigating detective and the PSU investigator both subsequently agreed that the sounds on the 911 call warranted an escalated response.

    d. The IoP investigation reviewed the audio recording of the decedent's 911 call. The sounds are conspicuous. At a minimum, the call should have been forwarded for review by a communications supervisor, which almost certainly would have led to a call for service being generated.

2. **The internal investigation, exemplified in the PSU Report, focussed narrowly on the issue of misconduct and did not address other relevant issues.**

    a. By focussing exclusively on misconduct, the internal investigation failed to address relevant issues that might have led to the mistaken classification of the call as a *silent cell*.

    b. A more expansive approach that included a review of staffing, the number and type of calls and noise environment at the time of the call, as well as a nuanced review of the applicable policies would have provided considerably greater insights into what went wrong that night.

c. While the NRPS attempted an environmental scan of other PSAP policies for *silent cells*, it is not clear how the survey results were used. The data provided to the NRPS was summary in nature and lacked any analysis including meaningful comparators to each other or to the NENA standards.

d. The internal investigation lacked any analysis that considered the distance between mistake and misconduct in the actions of the call taker. A finding of "mistake" can still be useful as a tool for considering performance improvement plans for individual members, PSAP procedures and the adoptions of new technologies.

3. The NRPS repeatedly characterised the call taker's evidence relating to the decedent's 911 call inaccurately.

a. The call taker expressly told the PSU investigators in an interview that the call taker had no memory of the call. The call taker's evidence was that *if* the call taker had heard something that caused them concern, the call taker would have escalated her response and generated a call for service. The call taker never stated that she had failed to hear sounds on the 911 call – the call taker denied remembering the call entirely.

b. The PSU interview with the call taker was conducted 7-weeks after the incident. The Chief and command staff admitted in their July 25 meeting with the family that the Communications Unit had spoken with the call taker the day that NRPS learned of the decedent's 911 call. No explanation was provided in the PSU Report for the delay in conducting the interview.

c. The IoP investigation reviewed the audio recording of the interview with the call taker. It lasted 6 minutes, during which time the PSU investigator made repeated use of highly leading questions, which steered the call taker to answers that accorded with NRPS policies.

d. The call taker admitted at the beginning of the interview to having no recollection of the 911 call in question, but quickly adapted to the leading questions, offering a series of responses about how the call taker would have responded had the call taker heard any "sounds of concerns".

e. This “new” narrative distorted the NRPS response. With the call taker admitting no memory of the incident, the NRPS should have determined factually what was happening at the time of the call at the call taker’s station and elsewhere in the Communications Unit. There is no evidence in the PSU Report that this type of inquiry was undertaken.

f. Subsequently, the NRPS position became that their call taker had not heard any noises on the 911 call that should have escalated the response.

g. It was this position that created the consequent friction between the complainant and the NRPS response, given the conspicuousness of the sounds on the decedent’s 911 call.

4. The current NRPS SOPs are inconsistent in how they address cellphone calls to 911, and differ markedly from how they address landline calls to 911.

a. Calls to 911 from landlines, where voice contact cannot be established, will lead to a police response in most circumstances.

b. [Redacted – s 1(1)1 – O Reg 317/24]

c. By comparison, a call to 911 from a cellphone where the call taker can hear nothing can be cleared with no reference to the location information or the need to engage a supervisor for a call review.

d. Although addressed more generally in the SOP, the *silent cell* procedure fails to explicitly account for the possibility that the caller may suffer a disability (*e.g. deafness, muteness*) that makes voice contact impossible. In the July 25 meeting with the complainant, the NRPS command staff explained that they rely on persons with a disability to “register” with them ahead of time to avoid this outcome.

5. **The current NRPS SOPs lacks a clear definition of "sounds of concern".**

    a. The SOP does not provide any guidance in the definition section or elsewhere as to what constitutes a "sound of concern".

    b. Call takers are provided with some guidance in the training programme, but it appears to focus instead on examples of sounds that do not raise concerns – *e.g.* traffic, regular conversation, etc.

    c. Other PSAPs, previously inspected by the IoP or canvassed as part of a jurisdictional scan, do not employ the term "sounds of concern" and its attendant threshold. Instead, they focus on the presence or absence of sounds in all of the surrounding circumstances.

    d. Importantly, the NRPS training bulletin, dated September 4, 2024, that was produced in response to this incident, included one step that is not included in the current protocols for *silent cells*: <u>When in doubt, ask a Supervisor! They can play the call back and help you determine if there are any unconfirmed background noises, sounds of a struggle, etc</u>.

6. **Following the PSU Report, the NRPS struggled to balance their obligations to the complainant with their other legal obligations.**

Inspectorate of Policing

777 Bay Street, 7th Floor
Toronto, ON M5G 2C8
Tel: +1-416-873-5930 or 1-888-333-5078
www.iopontario.ca

Improving policing performance to make everyone in Ontario safer.

Ce rapport est aussi disponible en français