

REPORT SNAPSHOT

Ontario Chief Coroner's Report on Police Officer Deaths by Suicide

Staying Visible, Staying Connected, For Life - Report of the Expert Panel on Police Officer Deaths by Suicide (September 2019)

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THE PANEL'S CENTRAL FINDING

The nine deaths did not follow one prototype. In every case, however, risk intensified where **three pathways converged**: (1) acute mental-health issues, often with substance use; (2) lost or diminished access to timely, appropriate care and support; and (3) actual or perceived disconnection from family, friends or the police organization. The report therefore focuses upstream - on changing conditions before crisis narrows a person's options.

What the panel found in policing

- **Identity and stigma:** Policing is often experienced as a calling. A binary 'fit or unfit' culture can turn psychological difficulty into a feared loss of identity, encouraging concealment, self-stigma and delayed care.
- **High-risk transitions:** Disclosure, medical leave, benefits, accommodation, disciplinary or criminal processes and public exposure can interrupt care and intensify stress. Return to work stood out as the most frequent recurring risk point.
- **Fragmented access:** Privacy fears, benefit limits, uneven peer-support standards, shortages of police-informed clinicians and limited rural or remote options can produce stop-start treatment or withdrawal from care.
- **Organizational pressure:** Understaffing and overtime contribute to burnout and can create pressure to rush return-to-work decisions or resentment toward members who are absent or accommodated.

Seven pathways to better outcomes

#	PATHWAY	WHAT IT MEANS
1	Normalize mental health challenges	Make mental health a routine, career-long and family-inclusive subject; link help-seeking, treatment and recovery to professional performance rather than weakness.
2	Navigate transitions	Provide consistent navigation and support through disclosure, leave, accommodation, benefits and especially return to work.
3	Ensure continuing quality care	Make sustained, evidence-based, police- and trauma-informed care universally accessible, with fewer financial and administrative barriers.
4	Address resourcing and burnout	Recognize staffing vacancies and medical leaves in workforce planning; protect dignified work and reduce resentment toward accommodated members.
5	Preserve identity during crisis	Maintain clinical and organizational connection when criminal or Police Act charges, removal of use-of-force options, or media attention threaten a member's identity.
6	Manage suicide events	Track and review deaths, support bereaved families and colleagues, plan postvention and reduce possible contagion effects.
7	Create joint ownership	Adopt a coordinated, no-wrong-door system involving government, services, boards, associations, clinicians, insurers, researchers, members and families.

Important observations behind the recommendations

- Fear that disclosure will damage reputation or career prospects can prevent members from using employer-linked care and benefits.
- Families are often excluded from the care path even though they may be the first to notice change and the most consistent source of connection.

FROM FINDINGS TO ACTION

The 14 recommendations - grouped for quick reading

The formal package contains 14 recommendations and 36 actions or specifications. The table below groups related recommendations without changing their intent.

ACTION AREA	REC.	WHAT THE REPORT CALLS FOR
Provincial leadership and accountability	1	Create the Ontario Police Members Mental Health Collaborative as a standing, quarterly body with shared leadership, metrics, timelines, research priorities and semi-annual progress reporting.
Culture, education and normalization	2-3	Run a province-wide normalization campaign and translate best evidence into practical education for members, leaders, families, peers, clinicians, police academies and post-secondary programs.
Service strategies and family access	7-8	Require each police service to maintain a comprehensive mental-health and wellness strategy, include family engagement, establish leadership competencies, and provide member-and-family information portals.
Care standards and access	4-6, 11-13	Set qualifications for clinical and peer support; maintain a living referral source; implement no-wrong-door access; expand police psychologists and collaboration; strengthen police-community mental-health partnerships.
Accommodation and high-risk hand-offs	9-10	Create best-practice accommodation and return-to-work processes, with clear roles and supportive connection. Establish hand-off protocols during charges, removal of use-of-force options and adverse media exposure.
Tracking, death review and learning	14	Require coroners to report first-responder suicides, initiate death reviews, maintain a data system and use cumulative analysis to improve the mental-health ecosystem.

Additional system observations

- Accusations of malingering, undignified modified duties and uncertainty about how to stay connected can deepen isolation during accommodation.
- The report calls for a prepared response after a suicide: support for bereaved families and colleagues, respectful memorialization, long-term follow-up and attention to possible contagion risk.

How to read the report

SCOPE AND CAUTIONS

This was an expert-panel review of nine anonymized Ontario cases, informed by research, professional experience and survivor interviews. It was not a causal or population-rate study. Because Ontario did not require systematic tracking of first-responder suicides, the panel could not establish whether the 2018 count was higher than previous years. Its 2020-2021 implementation dates are historical targets, not proof that the recommendations were completed.

BOTTOM LINE

The report rejects an individual-resilience-only response. Its core proposition is systemic: prevention requires a culture in which people can remain visible and connected, sustained access to qualified care, family inclusion, carefully managed transitions, coordinated governance, data collection and accountable follow-through. In the panel's words, **'broken toys can be repaired.'**

Source: Ontario Office of the Chief Coroner, Staying Visible, Staying Connected, For Life (September 2019). [Official Ontario online report](#) | [Full 29-page PDF](#). This snapshot is a concise summary; consult the full report for exact wording and context.