

IMPLEMENTATION STATUS OF THE 2019 CHIEF CORONER'S RECOMMENDATIONS

Independent companion assessment to Staying Visible, Staying Connected, For Life: Report of the Expert Panel on Police Officer Deaths by Suicide

Bottom line: Ontario has built meaningful mental-health infrastructure since 2019, but only 3 of 14 recommendations appear fully implemented on a strict province-wide reading. Eight show partial implementation and three are not publicly demonstrated. Most original deadlines were in 2020-2021.

3

FULLY IMPLEMENTED

8

PARTLY IMPLEMENTED

3

NOT PUBLICLY
DEMONSTRATED

11/14

SOME ACTION IDENTIFIED

Assessment standard. **Implemented** means the recommendation's core requirements are publicly verifiable and available province-wide. **Partly implemented** means meaningful action exists but a material requirement involving scope, access, standards or accountability remains. **Not publicly demonstrated** means reliable public evidence of province-wide completion was not located. Internal or unpublished initiatives may therefore affect the count.

Recommendation-by-recommendation assessment

#	RECOMMENDATION	STATUS	PUBLIC-EVIDENCE ASSESSMENT
1	Provincial collaborative	PARTLY IMPLEMENTED	The Mental Health Secretariat and police collaborative table were established and meet at least quarterly. Public evidence does not show every original governance element, measurable target, semi-annual report or continuing base-funding commitment.
2	Normalization campaign	PARTLY IMPLEMENTED	An Anti-Stigma Strategy, digital resources and leadership training are being rolled out. Completion across every police service, academy and relevant post-secondary program has not been demonstrated.
3	Knowledge translation	PARTLY IMPLEMENTED	A Joint Knowledge Sub-Committee, resource portal and training initiatives exist. Province-wide measurement of application, retention and continuous updating is not publicly demonstrated.
4	Provider and peer standards	PARTLY IMPLEMENTED	Vetted programs and peer-support training now exist, and a best-practice guideline was under development. No published province-wide qualification standards for all clinical and peer-support providers were located.
5	Living referral source	PARTLY IMPLEMENTED	Warrior Health supplies a provincial digital entry point and partner resources, but it is not a single consolidated system showing direct clinician availability across all regions; its FAQ directs users to partner provider lists.
6	No-wrong-door access	PARTLY IMPLEMENTED	Anonymous digital access, 24/7 navigation and peer supports reduce barriers. Direct clinical care and organizational services still vary, and a universal policy eliminating administrative and funding barriers was not demonstrated.
7	Every-service wellness strategy	NOT PUBLICLY DEMONSTRATED	Some services have comprehensive strategies, but no public evidence shows that every Ontario police service completed the full strategy, family-engagement and leadership-competency requirements.

Recommendation-by-recommendation assessment (continued)

#	RECOMMENDATION	STATUS	PUBLIC-EVIDENCE ASSESSMENT
8	Member and family portals	IMPLEMENTED	The Mental Health Secretariat launched a member-and-family portal, now expanded through Warrior Health's secure web portal and app for public-safety personnel and families across Ontario.
9	Accommodation and return to work	NOT PUBLICLY DEMONSTRATED	Service-level programs exist, but no public province-wide best-practice guideline was located covering accommodation, return-to-work decisions, defined roles and continuing connection with the member.
10	High-risk hand-offs	NOT PUBLICLY DEMONSTRATED	No public province-wide protocol was located for coordinated hand-offs during charges, removal of use-of-force options, or intense mainstream and social-media exposure.
11	Police-employed clinicians	PARTLY IMPLEMENTED	Ontario funded 20 additional mental-health support positions for the OPP, and several services employ specialists. Province-wide uptake or a shared-service model for smaller police services is not publicly documented.
12	OACP psychology committee	IMPLEMENTED	The OACP Psychological Services Committee is active, with a mandate covering assessment, treatment, research, training, policy and the exchange of best practices.
13	Police-health crisis partnerships	IMPLEMENTED	Ontario funded expansion of mobile crisis response teams in 28 communities, satisfying the recommendation's central call to encourage more police-health partnerships.
14	Coroner reviews and data	PARTLY IMPLEMENTED	A 2023 Chief Coroner policy created a police-member suicide review procedure, database and analytics process. Reviews remain discretionary and police-specific rather than mandatory for every first-responder suicide.

Five priorities still requiring completion

1	A comprehensive, accountable mental-health and wellness strategy in every Ontario police service.
2	Province-wide clinical and peer-support qualifications, with a living referral and direct-access pathway.
3	Consistent accommodation, return-to-work and high-risk transition hand-off standards.
4	Mandatory review and standardized data capture for every first-responder death by suicide.
5	Public implementation reporting using measurable timelines, outcomes and responsibility assignments.

Conclusion. The province has created a credible foundation, particularly through collaborative governance, digital access and crisis-response partnerships. The remaining work is less about announcing new programs than ensuring consistent standards, direct access, continuity of care and public accountability across every service.

Sources

1. [Ontario Chief Coroner, recommendations for action \(2019\)](#)
2. [Ontario Ministry of the Solicitor General, 2022-2023 published plan](#)
3. [Milliard & Christmas, Mental Health Secretariat: Collaboration for PSP mental health in Ontario \(2023\)](#)
4. [Ontario, Mental Health Supports for Public Safety Personnel and Anti-Stigma Strategy \(2024\)](#)
5. [Warrior Health, current program and access FAQ](#)
6. [Ontario, expansion of OPP mental-health supports \(2021\)](#)
7. [Ontario Association of Chiefs of Police, Psychological Services Committee](#)
8. [Ontario, expansion of mobile crisis response teams \(2022\)](#)
9. [Office of the Chief Coroner, Police Service Member Deaths by Suicide Review, Policy 4502 \(2023\)](#)

Prepared by Beyond Resilience Canada. Independent and non-partisan; not an official Government of Ontario audit. Content note: discussion of suicide and occupational mental health. Links are active in the digital PDF.

ORGANIZATIONAL TRAUMA: A CROSS-CUTTING NATIONAL ISSUE

The coroner report's underlying theme - and why Canada's policy response must go further

Beyond Resilience Canada working definition. Organizational trauma is psychological harm caused, intensified or prolonged by workplace systems, leadership conduct, investigations, discipline, isolation, staffing pressure or institutional betrayal. It also includes collective harm within a police service following a member's suicide or another critical event.

What the coroner report already recognizes

CULTURE + IDENTITY Stigma, hostile assumptions, marginal duties and the 'broken toy' mentality can erode professional identity and separate injured members from colleagues and organizational supports.	TRANSITIONS + RETURN TO WORK Return-to-work decisions were associated with worsened health, conflict with the organization and peers, professional-standards issues and financial stress.
INVESTIGATIONS + HAND-OFFS Charges, duty restrictions and public exposure can become acute precipitating events. The report calls for connection and continuity of care regardless of the allegation.	STAFFING + BURNOUT Understaffing and overtime transfer the burden of vacancies and accommodations to remaining members, contributing to burnout, resentment and further stigma.
SUICIDE POSTVENTION Every service should have a prepared organizational response to support families and colleagues, reduce contagion risk and address long-term consequences.	LEADERSHIP + SYSTEM OWNERSHIP Supportive behaviour should be a leadership competency. The report calls for service-level strategies and coordinated provincial responsibility rather than fragmented programs.

Where the report stops short. It does not establish an explicit organizational-trauma framework or province-wide standards for psychologically safe internal investigations and discipline. It does not measure institutional betrayal, command-caused harm, fear of reprisal, workplace trust or organizational repair, and it provides no restorative process for a workplace whose systems or leadership have contributed to injury.

Direct connection to the Beyond Resilience Canada white paper

A Coordinated Government Response to Police Suicide and Occupational Mental Health in Canada makes the organizational dimension explicit. It identifies harassment, poor supervision, disciplinary processes and fear of career consequences as contributors that can deepen psychological injury. It also states that resilience training cannot compensate for understaffing, excessive overtime, bullying, prolonged discipline or institutional betrayal.

1	Embed psychological health as a duty of care in staffing, supervision, labour relations, occupational health and police governance.	2	Provide direct independent clinical access and legally protect voluntary treatment records from routine employment and discipline use.
3	Require rigorous, timely and humane investigations and discipline, with no prolonged isolation and with continuity of care maintained.	4	Prevent chiefs, deputies and commanders from overriding independent clinical advice on treatment, claims or return to work.
5	Publish workplace-climate, staffing-pressure, access, sustainable return-to-work, member-trust and investigation-timeline indicators.	6	Use independent inspectorates to audit compliance and require prepared organizational postvention plans after every member suicide.

Implementation implication. Organizational trauma should be used as a formal test of Recommendations 7, 9 and 10. A service should not be assessed only by whether it offers a wellness program, but by whether its leadership, staffing, investigation, accommodation and return-to-work systems reduce avoidable harm and preserve trust.

Sources for this section

1. [Ontario Chief Coroner, Part 2: workplace stressors, accommodation and organizational disconnection](#)
2. [Ontario Chief Coroner, Part 3: transitions, burnout, hand-offs and postvention](#)
3. [Ontario Chief Coroner, Part 5: Recommendations 7, 9 and 10](#)
4. Townley, J. Bruce. A Coordinated Government Response to Police Suicide and Occupational Mental Health in Canada. Beyond Resilience Canada, August 2026.

This organizational-trauma definition is a Beyond Resilience Canada policy formulation; it is not a defined term in the Chief Coroner's report.