CRIMINAL LAWYERS' ASSOCIATION

February 26, 2014

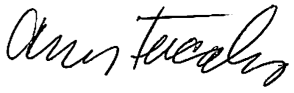
The Honourable Frank Iacobucci
c/o Ryan Lax
The Independent Review of the Use of Lethal Force by Toronto Police Service
79 Wellington Street West, Suite 3000
Box 270, TD Centre
Toronto, ON M5K 1N2

Re: Independent Review of the Use of Lethal Force by Toronto Police Service.

Thank you for providing the Criminal Lawyers' Association with the opportunity to make submissions to the Independent Review of the Use of Lethal Force by Toronto Police Service. Enclosed please find our submission.

We welcome the opportunity for further dialogue on this subject. We acknowledge that our submission will be made public.

Sincerely,



Anthony Moustacalis
President
Criminal Lawyers' Association

189 Queen Street East, Suite 1
Toronto, ON M5A 1S2
Tel: 416-214-9875
anthony@criminallawyers.ca

Submission from the Criminal Lawyers' Association (CLA) To The Independent Review of the Use of Force by the Toronto Police Service (TPS)

February 26, 2014

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
Tel: 416-214-9875 / Fax: 416-968-6818
www.criminallawyers.ca / anthony@criminallawyers.ca

The Criminal Lawyers' Association (CLA)

The CLA is the voice of the criminal defence bar in Ontario. With its membership nearing 1200, the Association has concerns about the Toronto Police Service's use of lethal force, particularly in relation to individuals with mental health issues, mental disability, or in crisis. The Association's members represent such vulnerable individuals in criminal courtrooms in relation to charges they incur, but also provide representation to mentally disordered offenders who are unfit or not criminally responsible. The Association, qua Association, has special expertise and interest in mental disorder matters and has intervened in litigation relating to the *Charter* and other legal rights of this client group, including in Inquests related to their death. The Association is grateful for the opportunity to contribute to this critically important independent review of the TPS' Use of Lethal Force in relation to individuals with mental health issues or disability.

The Perspective of the Association

The Association's submissions are informed by in-depth up-close experience and expertise of some of its members, gained through the historical, recent and ongoing litigation of all of the issues within the scope of this Review. In particular, members of the Association, as counsel to other concerned stake-holder groups, or families of those killed in such encounters, have historically participated in Inquests looking into policing practices in respect of use of force in relation to mentally ill individuals. Over the past year and a half, some of our members have been involved with the combined death Inquiry into the police shootings of three individuals known to be in emotional crisis at the time of their death (the JKE Inquest) and a related Inquest into the death of a mentally disabled non-verbal man who died in restraint during an arrest by officers who had mis-identified the man as a suspect wanted for breach of an alcohol prohibition term in a recognizance (the McGillivary Inquest.) The evidence and recommendations, which emerged from these proceedings, inform the submissions of the Association.

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
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Broad-Strokes Problems Identified – a Big Picture Snap Shot

1. The Public's Perception

(a) – Excessive Use of Force

As the Chief must be acutely aware, Toronto citizens are asking whether the TPS' primary response unit (ie front line officers) are too quick to fire, particularly at individuals in emotional crises. The shooting of Sammy Yatim was just the most recent and perhaps most inflammatory set of facts, highlighted by the civilian video of the death made widely available through social media. However, prior to the Yatim shooting, public outrage, alarm and outcry, was already escalating, on the heels of four such deaths within 18 months. Reyal Jardine Douglas died on August 29, 2010, Charles McGillivary on August 1, 2011, Sylvia Klibingaitis on October 7, 2011, and Michael Eligon on February 3, 2012. Each of these deaths, to varying degrees, drew community responses ranging from questions being asked to vocal and protracted protests and political action, from communities who themselves felt traumatized by simply bearing witness to some of these deaths (for example, Eligon.) These four individuals all died at the hands of police in that year and a half period, albeit that Charles McGillivary's circumstances did not mirror the others'. We will address the particular issues examined at the Inquests into these deaths, below.

(b) EDPs and/or Racialized Minorities are at Particularly High Risk

Given that those who tend to die at the hands of the police appear, anecdotally in any event, to fall into one or both of these groups: "Emotionally Disturbed Persons" [EDPs] or "Racialized Minorities," the public's perception is that mentally ill or mentally disabled individuals or those in emotional crisis and generally black people, are particularly at high risk of dying in encounters with police. Those who fit both categories are at even greater risk. Toronto citizens worry for the safety and for the lives of young black people, particularly, young black males, who are experiencing a serious mental health issue at the time of coming into contact with police.

(c) Too Many Cooks in the Kitchen –Who does What?

The public focuses its anger on the TPS – but also does not understand the role of other agencies, government actors, in setting policy, regulations, standards, training to front line officers, recruits, oversight, civilian and

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criminal, the role of the Special Investigations Unit. The complexity of the system in Ontario, in relation to legislation, regulations, policy, protocols, practices, training, investigation of conduct of officers, internal discipline, civilian oversight, criminal charges and related issues is astounding. It is difficult to follow after many months of evidence detailing the respective roles of the players. The TPS' website is unhelpful and dated. There needs to be some basic mechanism of educating the public on who does what. Ideally, the role various players fulfill in relation to the many factors that ultimately culminate in a fatal shooting of an EDP by a front line officer, should be readily accessible so that the public would at least be in a position to contribute to the public dialogue and meaningfully comment / complain / make suggestions for improvement. The system itself could use an overhaul (a serious simplification of the web of oversight and regulation currently muddying the waters) so that there is less room for adversarial relationships developing among stake-holders in policing, particularly over hot-button or divisive issues, the best example of which are the threshold for use and availability / distribution of Conducted Energy Weapons (CEWs or TASER.) We will revisit this issue below.

2. Lack of Data on Who is At Risk, exactly, and why

The TPS does not maintain Use of Force data in a way that allows the information to be scrutinized to verify or rebut the perception of at-higher-risk populations. The explanation for the failure to maintain statistics identifying those who die (or are seriously injured) in police interactions, by race or mental disability or crisis, appears to be the concern that data collection in this way might run afoul Human Rights Legislation. In this regard, TPS should be directed to the Ontario Human Rights Commission's "Count me In[1]" educational document, making it very clear that data collection that does not include personal identifiers like name and address, but does assist with identifying who is at risk in these interactions, would be not only permissible, but desirable and indeed vitally important.

The statistical analysis brought to bear on TPS' Use of Force is also impeded by insufficient details of the interaction collected on the Use of Force and Injury forms themselves – and the failure to have a provincial Use of Force Data Repository which would permit the TPS to evaluate its own Use of Force statistics against provincial outcomes – in an electronically searchable fashion.

[1] **Available online at http://www.ohrc.on.ca/en/count-me-collecting-human-rights-based-data**

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There is room for improvement for more particulars of each interaction to be accurately recorded and used for statistical metrics analysis, without personal identifiers. This could only help to implement strategies going forward, with a view toward minimizing risk of fatal outcomes.

3. Politicization of the Chief's Office – and that of the TPS

The TPS and the Chief, depending on who IS Chief, will align itself / himself, from time to time, to some extent more with the public interest approach / mandate of the Toronto Police Services Board or that of the Toronto Police Association, which protects the rights of and advocates in the interest of the officers themselves. It frankly impedes the prevention of future deaths in similar circumstances, if the Chief is at odds, or worse, with the Board, which sets its policy mandate and controls its funding decisions. It also does not help matters if the Chief or the Service are themselves determined to protect or advocate the position of individual officers involved in lethal outcome scenarios, as a knee-jerk first response, or throughout proceedings examining the matter. The Chief and the Service should keep an appropriate legal distance from the involved officers during legal proceedings examining their conduct in any public forum, and allow the TPA to take control of that situation in assisting the officers by providing the necessary legal assistance – the Police Association quite appropriately represents the collective and individuals interests of the officers, and does it well. The Chief ought not to duplicate these efforts.

The TPS would be better served by an improved working relationship with the Board, which ultimately prescribes the broad-strokes policies for which the Chief and the Service then promulgate operational protocols or procedures in accordance with the policy direction set by the Board, based on the public's interest and taking into account public consultations. Equally, the TPS' relationship to the SIU, when adversarial and uncooperative is not helpful. It would be of benefit to the public to re-iterate the role and mandate of the stakeholder organizations and associations and each confine itself to fulfilling its own mandate without creating unnecessary distractions by drawing battle-zones. These comments apply equally to the relationship of the Chief to the Ministry and the Ontario Police College and the Civilian Oversight body. Public confidence in the Police Services Act proceedings is also undermined if the Service and/or Chief are too closely aligned with individual officers and invested in protecting their actions. In the Inquest context, it should never even be contemplated that the Chief's lawyers would represent individual officers involved in a fatal outcome.

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
Tel: 416-214-9875 / Fax: 416-968-6818
www.criminallawyers.ca / anthony@criminallawyers.ca

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4. Transparency and Accountability

The TPS, not unlike the RCMP some years back, is currently experiencing a significant loss of public confidence. Incidents like the Yatim shooting have brought to the forefront the need for transparency and accountability for the role of the TPS in training and resources devoted to avoiding such lethal outcomes. There is an organization devoted to this issue, known as the Toronto Police Accountability Coalition, founded and operated by former Mayor John Sewell. The TPAC has tremendous institutional and historical wisdom and insight, which should receive greater respect. For instance, the Coalition made thoughtful written submissions[2] on the issue of police interactions with EDPs. It is possible that its contributions are dismissed or not paid enough attention because it is perceived as an activist organization with its own political, perhaps anti-policing agenda. This approach to the analysis and recommendations of the TPAC would be a misguided and shortsighted one.

The good news is that the TPS has made interaction with EDPs a priority and has devoted resources to working with the community of consumers and survivors (individuals with former or current involvement with Ontario's mental health system.) TPS has placed the mental health portfolio in the capable hands of Deputy Chief Mike Federico who personally takes on the task of liaising with the affected communities and has two decades of experience under his belt in this regard. The TPS also endeavours to take seriously recommendations arising from Inquests related to police interaction with EDPs, by and large. The current training respecting contact with EDPs is relatively solid, informed by the perspective of the consumer / survivor community, which has been given a voice by way of participation on the Toronto Police Services Board's (TPSB's) Mental Health Sub-Committee. To its credit, the TPS has taken these progressive and inclusive steps, implementing the very recommendations as they arose from previous Inquests into deaths of individuals in emotional / mental health crises, at the hands of police.

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[2] Dated March 28, 2012, in anticipation of the TPSB's April 19, 2012 meeting where the TPAC also made oral submissions – it should be noted that many of the recommendations the TPAC made in those submissions were ultimately echoed by the JKE Inquest Jury's recommendations released February 12, 2014

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
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However, at the same time, there are issues surrounding accountability in respect of bad outcomes and the TPS generally does not enjoy a stellar reputation for transparency or accountability. G20 obviously had a major role in the public's diminishing trust in our police force's interactions with the public. The particularly troubling ongoing controversy regarding carding practices has made things even more difficult. Inappropriate use of CEWs on vulnerable individuals or in circumstances where verbal de-escalation ought to have been tried or continued before invoking a use of force option, has escalated alarm in the public's mind. Finally, cases coming out of our Courts that make it clear some officers will turn off their In-Car-Cameras during interactions with the public where force is being used on members of the public, makes the need for increased accountability measures crystal clear. [3]

Ultimately, this discussion leads to only one logical conclusion: the TPS has to implement the use of body-worn cameras by all front line officers during all interactions with the public and as with in-car-cameras, the officers cannot retain any discretion to turn the recording devices off during such interactions. This is the way of the future. It's time to move beyond contemplating and begin implementing this ultimately cost-effective technology. While the cost associated with implementing body cameras for officers in a service the size of TPS is significant, once all competing considerations are factored in, the benefits would easily outweigh the costs in the long run. The obvious serious privacy concerns can be addressed and resolved with consultation on the issue and the appropriately necessary regulations promulgated by the Ministry. The cost associated with storage of data can be addressed by sensible policies on time limitations on retention[4] and the regular purging / destruction of video in respect of incidents reviewed and confirmed as unproblematic – perhaps coinciding with limitations periods in respect of mechanisms of complaint for police misconduct. Body-worn cameras implemented in other jurisdictions have resulted in an 80% reduction of complaints against officers[5] – an obvious side-benefit of the use of the technology, which should make it very attractive to explore. There would

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[3] See, for example, *R v Costain* [2013] O.J. No. 2289

[4] Perhaps six months or a year, up to three years – to be explored

[5] Self-Awareness To Being Watched And Socially-Desirable Behavior: A Field Experiment On The Effect Of Body-Worn Cameras On Police Use-Of-Force

http://www.bwvsg.com/wp-content/uploads/2013/07/The-Effect-of-Body-Worn-Cameras-on-Police-Use-of-Force.pdf

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likely be significant savings associated with reduction in legal fees / costs where complaints drop significantly. Video could also provide a definitive answer to vexatious litigation, further reducing those related costs. For our purposes here, having video footage of an incident in which police take the life of a vulnerable mentally ill individual, is the best evidence of that interaction that allows the most effective inquiry into the incident to proceed most efficiently. It does not leave to chance, as reliance on in-car-camera video technology risks doing, whether there will be an audio/video record of the interaction / event.

5. Police Culture – Taking & Maintaining Control of the Subject, the Scene

The generalized culture of policing involves asserting and maintaining control over every situation, subject, scene, quickly, efficiently and definitively. This alone leaves little room for the guiding principles that have been established to work best in interactions with individuals in emotional crisis or experiencing acute mental health issues. These folks need time and space. They need a softer, gentler, quieter, calmer approach than what officers are generally taught in terms of how to get that ultimate control over everything: by being loud, aggressive, asserting dominance, authority and gaining control. Albeit that EDP training by TPS makes the distinction clear, that training itself is insufficiently integrated into the sum total of the generalized training, and fades in the minds of the officers, over time, unless regularly reinforced at the Divisional level. Basically, the baseline paramilitary – ie 'force on force' - mentality is going to backfire where the individual is experiencing mental health issues. They won't respond appropriately, because they can't, and the effect of the interaction is to escalate, rather than de-escalate the scenario and the individual – risking a lethal outcome.

Police officers who work together grow to be good friends and loyal colleagues. They hesitate to dispute their colleagues' version of events because their solidarity to one another is uniquely strong, given they risk their lives for each other every day. This is understandable; however, when conducting a death inquiry into the lethal outcome of interaction with mentally ill folks, there can be no lessons learned going forward unless these incidents are accurately relayed by all subject and witness officers involved. The best way to prevent future death in similar circumstances is to use the knowledge-wealth from prior similar cases, to determine where mistakes were made and how not to repeat them. Officers should be reminded that there is no fault finding or legal liability of any sort attaching to a Coroner's Inquest.

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6. Impediments to Preventing Future Incidents – Learning from Mistakes

There is no way to prevent a tragedy once it has unfolded. However, lethal outcomes during police interactions provide the most immediately fertile ground for lessons to be learned for what not to repeat, where things may have gone wrong. This is obviously one place where body-worn cameras play a critically important role in letting reviewers, as well as the public, where / once appropriate, see what the officers on the front lines saw, as the incident / scene unfolded. In order to make maximal use of this information in relation to the incident that resulted in the fatality, however, the TPS has to be able to get on with the project of analyzing the scenario and utilizing it to prevent future such lethal outcome, immediately on the heels of the incident.

There appears to be an unfortunate institutional resistance, however, to even entertaining the possibility that these incidents could / should have been prevented, may be prevented in future. The underlying problem of course is the TPS is understandably nervous that any acknowledgement of the possibility of error will result in a host of adverse consequences for the involved officers or the Service. The SIU may lay criminal charges, families might sue – successfully - for damages, the Inquest process may cast criticism or censure on the officers or the Service, though prevented from making findings of legal liability, through recommendations pointedly aimed to effect change. The institutional anxiety of the Service is manifest through all of its communications publicly on such issues, from the press statements on the immediate heels of such tragedies all the way through to the manner in which surviving families of those killed in such events are often treated – without acknowledgement of loss, expressions of condolences or support services for them as victims traumatized by these losses.

Ideally the TPS would not concern itself with these potentially negative ramifications down the road, when turning its mind to how to immediately begin taking away lessons for future interactions from the tragedies as they unfold in real time. While the TPS voices its readiness to learn from and accept, even implement Recommendations from Inquests into lethal interactions with police, the Service does appear to essentially wait for these Inquests to really unpack what happened and for ideas on preventing future death in similar circumstances. They use Inquests as a major part of their "feedback loop." The JKE Inquest Jury returned its Verdict on February 12, 2014 in relation to three deaths spanning a year and a half period beginning in August of 2010 through to February, 2012. Obviously, more has to be done and more quickly. There should be a regularized process of de-briefing, beyond providing emotional support to subject or witness officers through therapeutic counselling. By way of quality

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
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assurance measures, and with some assurance that these feedback mechanisms would operate confidentially from SIU investigations or Police Services Act proceedings, officers still on the road should have the benefit of constructive feedback respecting such incidents where it is clear that the officer erred – whether and how or why not mattering, but there should be a mechanism for immediate feedback to involved officers. There should be education and training and critical incident debriefing more broadly delivered to Divisions where these incidents unfold, and throughout to all front line officers, where wisdom may be gained by closely scrutinizing these incidents immediately, not waiting for the often many years before an Inquest commences or concludes.

7. Pervasive Stigma and Stereotyped thinking about the Mentally Ill

Despite what are clear and obvious best efforts of both the Ontario Police College and the TPS to counter stereotyped notions of individuals with serious mental health issues as "dangerous" – it is apparent that many officers maintain these ideas. The general public, as lay persons, tend to hold these erroneous blanket beliefs. The reason this type of stigma is pervasive among police officers is based in the nature of their routine interactions with those in crisis. Outside of their initial training and only at the TPS (C.O. Bick College) where they come into direct contact with consumer / survivors not in crisis at the time of the interaction, front line officers see the client population only at their very lowest points in life, when they are, by definition, experiencing an acute mental health crisis. More often than not, this is in the context of some outstanding Form under the *Mental Health Act* (requiring police to take the individual into custody and transport them to a psychiatric facility) for execution by police, which signals to officers (not entirely accurately) that there is some imminent danger inherent in the interaction, which fuels the existing fear and stigma. The counter-measure for mutual fear of these interactions, is exposing officers to consumer / survivors in non-crisis situations. , The side-benefit of such engagement is allowing consumer / survivors to have positive interactions with police officers during encounters where the officer is not arresting or apprehending the individual. It is important to have such contacts, which do not feature officers transporting the individual to hospital / jail against their will, taking custody of them. Specifically to have ordinary interactions, where handcuffs make no appearance – the handcuffing procedure of *Mental Health Act* apprehensions regularly presents as one of the greatest contributors to bad feelings and fear of police by those with serious mental health issues.

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
Tel: 416-214-9875 / Fax: 416-968-6818
www.criminallawyers.ca / anthony@criminallawyers.ca

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8. Sheer Volume of Interactions with the Mentally Ill

Further contributing to the pervasive stigma of the dangerous mentally ill individual is the sheer volume of crisis interactions police have with clients when they have the least control over themselves or their situation, are most afraid, most panicked, and may have lost touch with reality. Most individuals with mental health histories harbour an acute fear of police. This fear is exponentially increased by each of the disproportionately high number of contacts they tend to have with police officers and the process of being handcuffed and forcibly taken to hospital for involuntary admission or arrested. As a result, the individual may behave in a way that leaves the officer with the impression of unpredictability or dangerousness, albeit that the behaviour is simply manifestation of fear or defending oneself. These behaviours, when seen routinely, leave a lasting impression with police of unpredictability and fear of violence, if not put into their proper context and understood.

To its credit, the TPS handles close to 20,000 EDP calls[6], with very few adverse or lethal outcomes, annually. However, there are other alarming statistics. Approximately 8600 of 19,000 such calls in 2011 alone resulted in *Mental Health Act* apprehensions, ie forcibly taking into custody of individuals in crisis. That is a very high percentage of coercive outcomes. This probably highlights the need for greater resources for community services for the client population, housing, supports, outpatient teams, non-medical intervention, social work, peer support, Gerstein Centre type mobile crisis – community diversion rather than hospitalization. Whatever accounts for this high level of forced hospitalization or custodial management of individuals in crisis calls for further study and research into 'pre-charge diversion' – linking individuals to community supports in place of criminal charges but also in lieu of hospital based assessments and for ensuring the front line officer is aware of existing resources. It is also critically important that the officer has the time and tools to make those links rather than simply transporting the person to hospital. The main reason these custodial apprehensions contribute to lethal outcomes down the road is that they are invariably accompanied by handcuffing, which the individuals in crisis by and large cannot tolerate. The experience leaves a lasting highly prejudicial impression.

The sheer volume of interactions police have with the mentally ill is a direct by-product of changes in civil mental health legislation in 2000 (Brian's Law) which

[6] As with other related data referenced in this submission, this was the evidence heard at the JKE Inquest

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
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expanded committal criteria and leaves it to police to enforce Community Treatment Orders (CTOs.) The number of occasions on which police are enlisted to enforce these orders has skyrocketed with the changes in the legislation. Unfortunately, front line officers continue to believe that the fact of an outstanding form requiring their involvement means the person poses a serious risk of bodily harm to themselves or others. However, these expanded committal criteria and CTO enforcements mean that the officer may be asked to collect someone who is only in breach of an Order requiring them to take their medications, and is being brought in for assessment simply because they may have missed a single dose. In other words, there is frequently not the slightest safety concern in the context of these apprehensions; police are simply involved as a mechanism to assist the individual to comply with treatment prescribed as a purely therapeutic intervention. There is room for more comprehensive education on the operation of Ontario's civil mental health system to front line officers. They currently receive this education from other officers and occasionally from mental health professionals, like psychiatrists. It should actually be provided by lawyers expert in the area, who have a real understanding of the legislation.

9. Myths about MCIT and about CEWs – the TPS' pursuit of funding

The TPS has two areas in which it wishes to expand and is intent on obtaining greater funding or authority, as is necessary, to obtain these goals. In the process, it is regrettable that, while not necessarily misleading the public, the Service appears content to leave the lingering misapprehension that either or both of these things would reduce or prevent lethal outcomes for individuals in emotional crisis, at the hands of police. The reality, however, is that neither Mobile Crisis Teams or "MCIT" (in their current formulation – ie the model TPS has adopted, which involves a civilian nurse as a member of the team) nor Conducted Energy Weapons or "CEWs or TASER," would have this effect. The reason is simple, in each case.

(a) MCIT

MCIT is not deployed to any situation where an actual crisis is unfolding, involving either any potential for violence or involving an EDP armed with a weapon. MCIT in its current formulation, because of the perceived risk to a civilian nurse or other mental health professional attending the scene, is disentitled to function as first responders and will only attend where the "crisis" is one limited to potential self-harm or an emotional crisis where MCIT can assess and determine if hospitalization is necessary or would be helpful

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
Tel: 416-214-9875 / Fax: 416-968-6818
www.criminallawyers.ca / anthony@criminallawyers.ca

or alternatively link the person to community resources. It is essentially a community mental health service, with the uniformed officer present to ensure safety of an apprehension, if one needs to be effected, pursuant to the *Mental Health Act*. This is not to say that it may not be worthwhile indeed to increase hours of operation, geographical availability, of MCIT – albeit that alternatives to the particular model adopted in Toronto also merit exploring[7]. The reality is simply that by the very terms of their existing mandate, they will do nothing to head off lethal outcomes in violent scenarios and/or those involving weapons.

(b) CEWs / TASERs

The public would have little reservation about the use of TASER / CEW in lieu of lethal force. It does seem eminently sensible to consider use of a TASER / CEWs on an individual in emotional crisis, who is perhaps armed with a weapon, where lethal force would otherwise be used, ie the person would be shot dead. However, this is not the use the TPS intends to make, or has made, of CEWs, except in a very few extraordinary circumstances, under particular conditions, and mostly in the context of the attendance of ETF, who already carry the devices. ETF utilizes CEW only with "lethal cover" or "lethal support" – ie, one officer deploys the CEW while another officer stands ready to shoot and kill the subject in case the CEW does not work. Other than that, the front line officer is NOT instructed to use CEW as an alternative to lethal force, and its use is not contemplated in that manner. Rather, CEW is an intermediate force option, same as batons or pepper spray. Its deployment is authorized, at the current threshold set out in Regulations promulgated by the Ministry, in response to assaultive behaviour. In fact, such assaultive behaviour does not need to rise to the level of posing a serious risk of bodily harm to the safety of the officer or anyone else. This is a lower threshold for use of CEWs than the Braidwood Inquiry ultimately recommended. With the threshold for use of CEW this low, the public maintains its fear of the devices, which themselves pose a potentially lethal risk. These concerns are compounded by the potential for

[7] **The JKE Jury identified other models to be explored – CIT, the Memphis model, ie no civilian nurse, just especially trained officers or the Gerstein Model or peer-support, ie non-clinicial, non-policing crisis workers are all ideas to explore**

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
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www.criminallawyers.ca / anthony@criminallawyers.ca

abuse of the device as a substitute for tactical communication (talking) or attempts to de-escalate, and ultimately as a tool to compel compliance.

10. Too many Reviews – Not Enough Commission of Public Inquiry

These comments are not intended, in any way, to take away from the importance of the review being conducted herein. This review is closest to the preferred model of receiving public input from a broad range of stake-holders, and it is heartening that the intention is to make public both the Report generated at day's end and the submissions received. That being said, one must pause to consider the context. First, at approximately the same time, Ombudsman Andre Marin has announced that his office is also conducting essentially the same review. Very little is known about the process undertaken in the context of that review, or its time-lines. Most recently, the Office of the Independent Police Review Director (OIPRD) has announced yet another review, that sounds very much like this one.

The Ministry of Community Safety and Corrections announced a provincial internal broad-scope review of the same issues, or related regulations, in May of 2012. There has been no public consultation in relation to that review and its progress or results have never been made public. Although in or around the summer / fall of 2013, the Ministry announced and then amended its Regulations, to permit local police services to expand distribution of CEWs / TASERs to front line officers, it never made public the process it employed to arrive at that conclusion, nor any consideration it may have given to what the appropriate threshold for deployment of the devices ought to be.

At the same time, several high profile Inquests into these very issues have been under way, as set out above. The TPSB has also conducted public consultations on the interaction of Toronto's police officers with EDPs (April 25, 2013) and on the use of CEWs in particular (in September of 2013). The Goudge Report on the Health Risks of CEWs was released in October of 2013.

There really is nothing wrong with any of these ongoing efforts and all are to be commended. However, there is significant overlap in the areas being canvassed, for one thing. There is a real risk of contradictory recommendations emanating from different review mechanisms, causing confusion and further erosion of public confidence. Further, the problems giving rise to the need for review are not limited to Toronto.

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
Tel: 416-214-9875 / Fax: 416-968-6818
www.criminallawyers.ca / anthony@criminallawyers.ca

There is no substitute for the comprehensive Inquiry of a Royal Commission or Public Inquiry, which hears *viva voce* testimony from involved individuals and experts, and permits that testimony to be tested by directly concerned individuals and groups / advocacy organizations / experts themselves in the issues. There is authority to call such a public Inquiry in the *Provincial Inquiries Act*. Ontario should exercise that authority so that the Province is able to arrive at standardized approaches consistent across the province maximizing the benefit of the wisdom and insight gained through this most effective mode of examination of a hugely pressing social problem that is costing the lives of our Society's most extra-ordinarily vulnerable citizens.

Specific Areas of Review Targetted – the Devil's in the Details

1. Lessons Learned from the JKE and McGillivary Inquests

By the time submissions are received by this Review at the end of the February, the Verdict and Recommendations in both these Inquests will be available. As a result, the Review will have the benefit of the wisdom of two lay Juries, who will have heard, in total, the evidence of more than 100 witnesses over a period of more than four months. Over the next short while, each Presiding Coroner (Dr. David Eden in the JKE Inquest and Dr. Dan Cass in McGillivary) will promulgate the Coroner's Explanation of the Verdict and Recommendation, which will chronicle the background facts, the relevant evidence and explain the rationale behind the recommendations the Jury made. There is little point in setting out here more than a cursory summary of the background and results of those Inquests, given the fulsome nature of the information about them that will soon become available for public consumption. The specific comments / recommendations we make, below, are not meant to revisit what these Juries have already said. They simply add to the discussion. While the combination of these two proceedings still falls short of what a Public Inquiry would / could accomplish, there has been a very full and fair examination, through testing of the evidence of factual and policy / expert witnesses into two particular types of tragedies:

(a) JKE Inquest

JKE reviewed the deaths of three individuals with histories of serious mental health issues, known to police, before they attended the scene, to have been in emotional crisis at the time, who were carrying edged-weapons and were shot to death by police. The 74 Recommendations are geared in some measure toward those particular circumstances which were common to

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
Tel: 416-214-9875 / Fax: 416-968-6818
www.criminallawyers.ca / anthony@criminallawyers.ca

these three deaths, albeit that they address, to some extent, the broader issues of police interaction with EDPs. One of the key recommendations the JKE Jury made was for the Office of the Chief Coroner to keep a proper database of Inquest Jury's Recommendations in related cases that is searchable and readily available. The JKE Inquest was perhaps the 16th or 17th Inquest going back to the 1991 or thereabouts Inquest into the late 1980s death of Lester Donaldson, to examine issues of Use of Force by the TPS in interactions with EDPs. Clearly, a critical analysis of what recommendations remain outstanding and why they have not been implemented, is a project that needs immediate attention. There is little point to recreating the wheel with each Inquest only to have pivotal recommendations disappear into the ether, with no enforcement mechanism to compel even a response from those to whom the recommendations are directed.

(b) McGillivary Inquest

McGillivary reviewed the elements of the sudden death of a man during the process of restraint in the context of a struggle during an attempt to arrest him albeit he was mis-identified as another man wanted for breach of the most minor alleged infraction of a bail condition – ie an alcohol prohibition. Mr. McGillivary's tragic death shone light on the particular problem of identifying those with invisible pervasive mental and/or communications disabilities such as cognitive impairment, not being able to vocalize or speak (non-verbal) and autism. It also highlighted, once again, the dangers associated with particular grounding techniques and positional / restraint asphyxia. Perhaps surprisingly, this Inquest demonstrated a glaring lack in TPS' front line officers' knowledge in assessing accurately the medical condition of those who experience an emergency in police custody and their ability to perform CPR in a timely and effective manner. It also showed, in this case, a lack of any constructive analysis or debrief of the incident, with no steps taken to critically examine it until the Inquest process, and then only with the participation of public interest interveners, finally permitted a full inquiry into the factual record. Finally, the critical importance of having AED (automatic external defibrillators) in every scout car was again made plain. Many of these recommendations had been made before but some clearly remain to be implemented. The Manon Inquest Jury in 2012 came to many of the same conclusions, albeit only some of their important recommendations were implemented in the intervening two years' time, unfortunately.

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
Tel: 416-214-9875 / Fax: 416-968-6818
www.criminallawyers.ca / anthony@criminallawyers.ca

2. TPS Policies / Procedures / Practices

In this section we identify some problems as they emerged in the Inquest litigation of the issues identified and offer some suggested recommendations for improvement. We are not repeating here the JKE Jury's own recommendations, which are attached. The suggestions below are offered in addition to those recommendations.

(a) Generally

(i) Accessibility / Transparency / Accountability

- Unless in a specific case, officer safety were compromised by making TPS Policies / Procedures / Practices publicly available, they should be
- Ideally, they would all be posted to the website of the TPS, available in a searchable format and down-loadable.
- Minimally, they should all be readily available to & shared among policing interests.
- One bizarre feature of these Inquests has been the difficulties encountered by and ultimately occasional inability of the TPS BOARD to gain access, through its own lawyers, to TPS documents relating to policy / procedure / practices from counsel to the Chief involved in the litigation.
- We can see no reason by TPS's documents setting out its policies / procedures/ practices should not be immediately accessible to the TPSB and the Ministry, the SIU, civilian oversight bodies / tribunals / agencies – and ultimately, unless safety issues seriously arise, to the public.
- We might make the same comment regarding all documents of the Ministry of Community Safety and Corrections, including all policing policies, standards, regulations and reports.

(ii) Content / Consistency / Language / Review Mechanisms / Updates

- There are too many documents and insufficient protocols in place for efficient and accurate document management.
- The current version of any particular document regarding policy / procedure / practices often prove difficult to identify, locate even by TPS own lawyers or their own staff who are tasked with document management.
- Certain key inherent / internal inconsistencies in documents covering the same or similar ground were identified in the course of these inquests (an

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
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example is referencing MHA 'apprehensions' as 'arrests' in some documents, resulting in confusion around the practice of handcuffing during such apprehensions – as the JKE Recs set out).

- There should be regularized periodic and frequent reviews of all these documents to ensure currency and consistency.
- Content of the documents should be reviewed by stake-holder groups or the Mental Health Subcommittee of the Board and available for public input, where appropriate.
- The Language of certain concepts should be reviewed with input from stake-holders: specifically, neutralizing the threat, 'engaging' with lethal force, 'engaging with handcuffs' – "deployment" of weapons / and so on.

(b) Specific Areas of Concern

(i) Use of Force

The "MODEL"

- The utility of the diagrammatical aid known as the Use of Force "Model" to new recruits / PRU front-line officers should be reviewed.
- While it is made painstakingly clear by Use of Force trainers that the model is not meant to "justify" use of force, it IS used in hind-sight to "explain" a particular use of force incident.
- It gives the impression of being a mechanism created and utilized to guard or defend against civil suit and damages.
- It is meant to be a "sphere" rather than a "circle" or "wheel" but if it is too difficult for 30 lawyers to grasp over several days' of explanation by way of testimony from those who teach it, perhaps it's a bit complex for new recruits in a couple of hours to internalize.
- It makes simple points that should be simply put to officers.
- It should emphasize to a much greater degree the need to de-escalate at every step.
- It should be modified or incorporate the specific training respecting EDPs.

The List Identifying Signs of Potentially Aggressive Behaviour

- In a particular policy document, TPS provides its officers with behaviours that may be seen as indicative of potentially aggressive behaviour, or a sign the "suspect" or individual may be about to attack.
- TPS needs to seriously reconsider the utility of a list of this nature

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
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- While obviously intended to alert officers to potential risks and danger and to maintain discretion as broadly as possible for offers to respond using a force option, the list leaves NO BEHAVIOUR the subject could exhibit, other than complying with the command given him, that could keep the individual from being hurt or killed by excessive use of force in response.
- That list lies at the heart of unacceptable outcomes for EDPs, because of the EDPs propensity to engage in all the behaviours listed – pacing, moving toward or away from officers, shouting, not responding, hiding and so on – all hallmarks of behaviour of EDPs frightened and confused in an altered state of reality and particularly frightened and disoriented by shouted commands.

The List of Signs for Evading / Fleeing Arrest – When to Stop Using Force At All

- It appears that officers believe that an individual who is unresponsive to "his" name being called out necessarily signals a suspect fleeing arrest.
- It simply must be reinforced for PRU front line officers that if someone does not respond to "their" name being called, that behaviour is much more likely to be consistent with the fact that the person is not the subject for whom the officer is searching, than that he is the right 'suspect'.
- Further, the idea that once the officer determines to effect an arrest, he / they must follow through, despite information coming to their attention that they may have the wrong person, should be corrected.
- Finally, the level of force brought to bear during an arrest situation cannot include all options, where the suspected offence for which the arrest process has commenced is an extremely low priority breach of a bail condition, such as alcohol-consumption, for instance.
- Policies / procedures / protocols must be amended to permit sufficient discretion to exercise common sense even if it means permitting a suspect in the process of being arrested, to escape custody, in situations where the foreseeable harm, if any, is minimal.
- Otherwise, as we have seen in McGillivary, there is a real risk of a lethal outcome that the public cannot countenance, given that the underlying concern that gave rise to the interaction is of negligible potential harm at best.
- In other words, the use of force must, at all times, be commensurate with, and reasonable, both subjectively AND objectively, the actual risk posed to the safety of the officer and the public, and no more.

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(ii) Communications / Dispatch / Who Should / Will Respond to EDP calls

- There are some policies, protocols / procedures / practice directions suggesting that the ETF and/or MCIT be notified in the case of every single EDP call and/or in those cases where a psychiatric patient goes AWOL from a facility.
- There is little to no clarity on what Dispatch / Call-Takers' roles are in identifying the appropriate policing response to any situation
- Clearly situations flagged as potentially violent / involving a weapon and an EDP are appropriate calls for ETF to attend and not appropriate for MCIT.
- Whether MCIT should be routinely involved in returning AWOL patients to psychiatric facilities is something that maybe should be entertained and processes built around that – however ETF is obviously overkill and a waste of their resources for such routine situations.
- There is a service gap in calls involving EDPs who are armed with a weapon now that ETF is not necessarily going to be the first responder and the PRU front-line officer is expected to address and go in to such situations.
- For this reason, TPS should explore having particularly highly trained in EDP contact front line officers identified and available on all shifts at each Division (what we would call the CIT model – ie MCIT trained front line officers, minus the civilian nurse, to allow for first responding officers with special training to attend such scenes).
- Wherever possible, there should be MCIT on hand, even including as first responders, routine EDP calls where there is no suggestion of the presence of a weapon or potential for violence.

(iii) MHA Apprehension Procedures

- The policy / procedure on use of handcuffs during all arrests is interpreted by officers as requiring the application of handcuffs during all *MHA* apprehensions.
- This ought not to be the case.
- It should be clear in a specific policy / procedure directive on this issue that NO HANDCUFFS are to be used during such interactions, unless there is a demonstrable need for them based on the behaviour exhibited by the EDP such that hand-cuffs are necessary for the safety of the officers / public.

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(iv) In Car Camera – operations

- There is some confusion in the existing, even currently as amended, policy on the use of In-Car-Camera video recording devices about when / where officers may exercise a discretion to turn the device off
- There appears to be a distinction drawn between "officer-initiated calls" – such as motor vehicle stops versus service calls initiated by a 911 call from the public.
- This interpretation leads to bizarre outcomes – so for instance, every suspected impaired driver has a video-recording of him being read his Charter rights, while whether we have a record of an EDP dying at the hands of police is a factor of happenstance as to whether the officer forgot to turn off the camera, which came on when lights / sirens were activated.
- Ultimately, the only consistent approach should be that officers have NO discretion to turn off the ICCs during interactions with the public.
- Particularly not where the ICC was turned on by operation of the sirens / lights, since in THOSE cases, the scout car was obviously on route to en emergent situation.

(v) What is a person in "crisis?"

- In an apparent effort to distinguish between individuals with a diagnosed or chronic major mental disorder experiencing an acute flare-up of their symptoms and someone who may be situationally depressed or anxious, the TPS has adopted a bizarre definition of crisis, which needs to be revisited, as it is apparently interpreted / utilized, among other things, to determine what calls may be appropriate for MCIT to attend.
- The specific definition is something like: "A person in crisis is help-seeking and in this way has demonstrated that they remain in touch with reality."
- Obviously, persons who are help-seeking and in touch with reality are the lowest risk group among those who may benefit from a policing response, including MCIT and ought to be linked to community based resources in a much less expensive fashion – if THEY are the target-market for MCIT then those with serious mental health issues who are in a true state of crisis, evidenced by in fact having lost touch with reality to at least some extent, need a different model of policing response altogether.
- MCIT – particularly if it is thought to be an appropriate response for those who are help-seeking, should be advertised as an available service, so the public is aware of it.

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
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www.criminallawyers.ca / anthony@criminallawyers.ca

- And the public, clients themselves and/or their families, should be able to access it (MCIT) directly.

3. Training

GENERALLY

- While EDP training is generally good and improving all the time at both the OPC and C.O. Bick (TPS) – it remains a distinct module, and is not sufficiently, or at all integrated within the Use of Force training modules, including specifically training on "edged-weapons".
- As a consequence, during crisis situations involving potential violence or EDPs with edged-weapons, officer mistakenly believe they have some kind of mandate to resort to lethal force – ie shoot to kill – EDPS who are unresponsive to shouted Police Challenge commands.
- The hierarchy in which training governs what situation must be unpacked to allow the front line officer to use common sense, good judgment and not be obsessing with the application of what are perceived as rigid "Rules" such as the "21 foot Rule" which is really not a rule, or even a true Guideline.
- Finally, NEITHER OPC nor CO Bick appears to have any regular training to new recruits about invisible disabilities, such as cognitive impairment or learning disabilities or pervasive intellectual delay, included in challenges such as autism spectrum disorders.
- There is a model for a good lecture by Training Constable Molyneaux, that was given only once to all front line officers in 2012.
- This lecture ought to form part of new recruit training at the OPC level some and some refresher or Divisional training at the TPS level.
- Both colleges need to add materials on how to communicate and safely handle interactions with those with communications challenges like hearing impaired or non-verbal individuals and or those who live with autism.
- Finally – CPR training, though frequent and reinforced, may need to be refreshed for officers who forget it – they should be tested randomly and routinely.

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
Tel: 416-214-9875 / Fax: 416-968-6818
www.criminallawyers.ca / anthony@criminallawyers.ca

(a) Ontario Police College

- The 12 weeks of training at the OPC is the shortest in North America
- As the JKE Inquest heard, they "don't have time to teach them to shoot and drive".
- It needs to be extended particularly because outside Toronto, the EDP training provided by OPC may be ALL that new recruits get
- The EDP training at OPC in some ways is excellent.
- It teaches officers about "the power of the uniform" in a way that is readily understood as 'negative' for EDPs.
- Unfortunately, this particular messaging is undone at the TPS, which communicates the opposite message at C.O.Bick and uses uniformed officers as members of MCIT.
- The materials OPC uses on EDP training are generally thoughtful and comprehensive.
- Two problems – the document "Not Just Another Call" places tremendous emphasis on specific psychiatric diagnosis and symptoms – it invites the suggestion that front line officers should / need to be able to diagnose specific mental illnesses – it also over-emphasizes the medical model based theory of mental illness over social factors and stressors - it should be reviewed with community partners, including input from consumer / survivors.
- There is a training video, whose post-production inclusion of scary, loud, dramatic music, together with the actors employed to play EDPs, has the overall effect of demonizing those with serious mental health issues – the last thing that is intended – it should be reviewed and consideration should be given to using training videos produced by consumer/ survivors as does TPS.
- Finally, consumers and survivors should have input into providing direct training at the OPC level to begin the process of sensitizing new recruits to individuals with histories of serious mental health issues, in situations other than during crises.

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
Tel: 416-214-9875 / Fax: 416-968-6818
www.criminallawyers.ca / anthony@criminallawyers.ca

(b) TPS – C.O. Bick College

- Subject to the caveat about stand-alone modules rather than fully integrating into Use of Force / edged-weapons training, TPS' EDP training is excellent and fully informed by the perspective of consumers / survivors including video-taped materials produced by that community.
- The problem is the extent to which this training is retained over time in the field.
- To this end, consideration should be given to pilot projects in Divisions where EDP contacts are highest, such as 14 Division and 51 Division to direct training by way of refresher in-service training, to be provided by consumer / survivors who have experience in providing such training to police officers.

4. Equipment Used by TPS

- Batons are potentially lethal weapons[8], but they play a role if properly used – they should be used / could be used and training on these lines should be considered – as an alternative to lethal force in edged-weapon situations.
- Tactical Shields should be available in scout cars to use defensively and offensively where a suspect is armed with an edged weapon.
- The Presiding Coroner in the JKE Inquest had ruled that that the Jury could not make recommendations regarding threshold of use for CEWs / TASER or regarding broader distribution.
- It's clear from the recommendations they DID make, that had they been permitted to do so, they would have recommended raising the threshold for use to at least the Braidwood standard if not only to be used as an alternative to lethal force.
- Before putting more CEWs into the hands of ANY front-line officers, the threshold for their use should be revisited, as the JKE recs suggest, through a very public and transparent consultation process.
- And a particular study to determine special health risks associated with the use of CEWs should be mandated.
- Finally, if CEWs are to be used, and in any event, body-worn camera technology needs to be implemented.

[8] Otto Vass died in 2000 while being beaten by batons of 4 officers – although the Inquest into his death (held in 2006) did not determine a cause of death

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www.criminallawyers.ca / anthony@criminallawyers.ca

- Critically important, however, is supplying AEDs (defibrillators) and equipment associated with performing CPR (gloves and mouth shields) to all scout cars together with the necessary training in their use – this will save lives where individuals otherwise die in police custody awaiting EMS / Fire.

5. Psychological Testing for Officers

- We should be screening out:

  (a) Those with anger-management issues
  (b) Those on performance enhancing drugs, such as steroids
  (c) Those on testosterone supplement therapy increasing aggression
  (d) Those who would be too quick to use force, as shown on testing
  (e) Those who would not be bothered by using their firearm to kill another human being, as shown on testing.

- Ideally the kind of person you want carrying a gun is the one who would be most loathe to ever use it.
- Officers should have confidence in their own ability to address situations which may present with some prospect of violence, without resort to lethal force.
- They should have exceptional communication skills and be good listeners and have naturally good judgment and ability to communicate calmly to restore trust and confidence.
- Psychological testing should be ongoing.
- During particular periods of stress unrelated to the job, officers should be given duties less likely to put them in the path of situations where lethal outcomes might result.

6. MCIT

- A permanent, enduring, ongoing advisory board with significant representation by the consumer / survivor community needs to be established.
- There needs to be maximal use made of the expertise and experience of those officers who have been MCIT officers – to make them EDP leaders at their Division during their service subsequent to their 2 year rotation on MCIT.

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
Tel: 416-214-9875 / Fax: 416-968-6818
www.criminallawyers.ca / anthony@criminallawyers.ca

- Those interested in becoming MCIT officers should receive additional preparatory training / mentorship from those who have rotated through MCIT.
- Self-selection for these positions will work best as those officers will demonstrate they are not fearful or prejudiced but willingly rise to the challenge of working with the client population identified as EDPs.

7. ETF

- ETF works great when they can get to an EDP / weapons call.
- There need to be more ETF teams albeit perhaps in smaller incarnations
- Some variety of ETF that can address less lethal but still more complex than appropriate for MCIT EDP calls with potential to escalate, should be contemplated.
- It's a winning model for those interactions that most often lead to lethal outcomes when handled by PRU without benefit of timely arrival otherwise of ETF.
- Consideration should be given to returning to a practice where the PRU / front line officer was not expected to enter a scene until ETF got there, where EDPs with weapons presented a real risk of lethal outcomes
- Regular updates on ETAs for ETF are a must.

8. Other Jurisdictions - Lessons Learned

- TPS should pay particularly close attention to lessons learned after public inquiries into high profile tragedies, in Memphis, San Francisco Bay Area (the BART shooting of Oscar Grant, 2011 – also the subject of a new film) and Portland (the movie Alien Boy is instructive).
- Recommendations for body-worn cameras came out of public inquiries into many of these deaths and were implemented in some.
- Our own Six Senators' Report into the RCMP's accountability – made similar recommendations regarding implementation of body-worn cameras.

IN CONCLUSION

Dozens of seriously mentally ill individuals have died, over the last number of decades, in confrontations with or during interactions with Toronto police officers. There have been death inquiries conducted on each occasion beginning at least as far back as the late 1980s with the death of Lester Donaldson. There is

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
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www.criminallawyers.ca / anthony@criminallawyers.ca

sufficient public concern voiced currently, that a concerted effort to address the use of lethal force in interactions with EDPs in Toronto is critically important and urgent. There are many reviews ongoing. There is great expertise in the various stake-holder organizations and among individuals who have followed the issue closely over the years. The CLA believes that a Public Inquiry during which evidence of factual and policy witnesses could be tested by interested and expert stake-holders, would ultimately address the issue most effectively, maximizing the chance of success in preventing future death in similar circumstances. However, the CLA recognizes the great benefit of independent review mechanisms, such as this, and is grateful to have had the opportunity to comment. We would be honoured to follow up, if appropriate, with a meeting in person, should that opportunity arise.

CRIMINAL LAWYERS' ASSOCIATION, 189 Queen Street East, Suite 1, Toronto, ON M5A 1S2
Tel: 416-214-9875 / Fax: 416-968-6818
www.criminallawyers.ca / anthony@criminallawyers.ca

Appendix A

Verdict of Coroner's Jury – Reyal Jardine-Douglas, Sylvia Klibingaitis, Michael Eligon (JKE)

Verdict of Coroner's Jury – Charles McGillivary

Office of the
Chief Coroner
Bureau du
coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

We the undersigned / Nous soussignés,

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de :

Surname / Nom de famile	Given Names / Prénoms
Eligon	**Michael**

aged / à l'âge de 29 held at / tenue à Coroner's Courts Toronto, **Ontario**

from the / du 15th October 2013 to the / au _____

By / Par Dr. / D' David EDEN Coroner for Ontario / coroner pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit :

Name of Deceased / Nom du défunt
Michael Eligon

Date and Time of Death / Date et heure du décès
February 3, 2012 at 10:37

Place of Death / Lieu du décès
St. Michael's Hospital, Toronto

Cause of Death / Cause du décès
Penetrating gunshot wound to right side of neck

By what means / Circonstances du décès
Homicide

_____ _____
Original signed by: Foreman / Original signé par : Président du jury

_____

_____

_____

_____
Original signed by jurors / Original signé par les jurés

The verdict was received on the / Ce verdict a été reçu le _____ (Day / Jour) day of / _____ (Month / Mois) 20 14

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)	Date Signed (yyyy/mm/dd) / Date de la signature (aaaa/mm/dd)
Dr. David EDEN	

_____
Coroner's Signature / Signature du coroner

Office of the
Chief Coroner
Bureau du
coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Inquest into the deaths of:
Enquête sur le décès de :

Reyal Jardine-Douglas, Sylvia Klibingaitis, Michael Eligon

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

We, the jury, wish to make the following recommendations:

KEY

CEW – Conducted Energy Weapon
EDP – Emotionally Disturbed Person
EMS – Emergency Medical Services
ETF – Emergency Task Force
ICCS – In Car Camera System
MCIT – Mobile Crisis Intervention Team
MCSCS – Ministry of Community Safety and Correctional Services
OPC – Ontario Police College
PRU – Primary Response Unit
SIU – Special Investigations Unit
TEGH – Toronto East General Hospital
TPC – Toronto Police College
TPS – Toronto Police Service
TPSB – Toronto Police Services Board

POLICE-RELATED

RESEARCH & ANALYSIS

Recommendation to the Toronto Police Service (TPS) and the Ministry of Community Safety and Correctional Services (MCSCS):

1. Conduct, jointly or separately, a comprehensive research study to establish metrics against which current and future police training (delivered by the Toronto Police Service and Ontario Police College respectively) can be evaluated to determine whether and how practices on which officers are trained are being adopted in the field.
    a. Among other things, the study should evaluate how much and how well training emphasizes communication strategies and de-escalation strategies, and how well the training explains the research-based rationales for such strategies.
    b. The study should also consider and evaluate:
        i. practices used to evaluate officer performance during and upon completion of training, and
        ii. the skills and training of officers delivering the training content.
    c. Finally, a protocol for the formal assessment of officers regarding the communication and judgement skills they demonstrate in training and while on duty should also be developed.

Recommendations to be addressed to the Ministry of Community Safety and Correctional Services:

2. Commission a study of CEWs to determine if there are any special risks or concerns associated with the use of this device on EDPs.

Office of the
Chief Coroner
Bureau du
coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

We the undersigned / Nous soussignés,

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de :

Surname / Nom de famile	Given Names / Prénoms
Jardine-Douglas	**Reyal**

aged / à l'âge de 25 held at / tenue à Coroner's Courts Toronto, **Ontario**

from the / du 15th October 2013 to the / au _____

By / Par Dr. / Dr David EDEN Coroner for Ontario / coroner pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit :

Name of Deceased / Nom du défunt
Reyal Jardine-Douglas

Date and Time of Death / Date et heure du décès
August 29, 2010 at 16:07

Place of Death / Lieu du décès
Sunnybrook Health Sciences Centre, Toronto

Cause of Death / Cause du décès
Penetrating Gunshot wound to the left shoulder

By what means / Circonstances du décès
Homicide

Original signed by: Foreman / Original signé par : Président du jury

Original signed by jurors / Original signé par les jurés

The verdict was received on the / Ce verdict a été reçu le _____ (Day / Jour) day of / _____ (Month / Mois) 20 14

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)	Date Signed (yyyy/mm/dd) / Date de la signature (aaaa/mm/dd)
Dr. David EDEN	

Coroner's Signature / Signature du coroner

Office of the Chief Coroner
Bureau du coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

We the undersigned / Nous soussignés,

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de :

Surname / Nom de famile	Given Names / Prénoms
Klibingaitis	**Sylvia**

aged / à l'âge de 52 held at / tenue à Coroner's Courts Toronto, **Ontario**

from the / du 15th October 2013 to the / au _____

By / Par Dr. / Dr David EDEN Coroner for Ontario / coroner pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit :

Name of Deceased / Nom du défunt
Sylvia Klibingaitis

Date and Time of Death / Date et heure du décès
October 7, 2011 at 10:26

Place of Death / Lieu du décès
Sunnybrook Health Sciences Centre, Toronto

Cause of Death / Cause du décès
Perforating gunshot wound of chest

By what means / Circonstances du décès
Homicide

_____
Original signed by: Foreman / Original signé par : Président du jury

_____

_____

_____

_____

_____
Original signed by jurors / Original signé par les jurés

The verdict was received on the / Ce verdict a été reçu le _____ (Day / Jour) day of / _____ (Month / Mois) 20 14

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)	Date Signed (yyyy/mm/dd) / Date de la signature (aaaa/mm/dd)
Dr. David EDEN	

_____
Coroner's Signature / Signature du coroner

3. Continue to research and consider police procedures when dealing with EDPs with edged weapons in other jurisdictions where either not all police are equipped with firearms or where police are prohibited from drawing their firearm unless they face a subject armed with a firearm.
4. To enhance the collection of data for analysis, amend the Use of Force form to include, but not limited to:
    a. the drawing and deployment of a CEW as one of the listed use of force options;
    b. a requirement that, if officers indicate on the Use of Force form that "verbal interaction" was an Alternative Strategy Used, the officers must also provide particulars in respect of that verbal interaction;
    c. a section to identify whether the use of force involved a subject whom the officer perceived was suffering from a mental illness and/or in emotional crisis; and
    d. an electronic format for improved input and tracking.
5. Create a provincial database to compile data obtained from the Use of Force Form, as amended in accordance with the recommendation above and to better track EDP calls and their outcomes

Recommendation to the Toronto Police Service, Toronto Police Services Board (TPSB) and Empowerment Council:

6. Consider a joint research project between TPS, TPSB, and community partners (e.g. Empowerment Council, academic institution) on best practices regarding police interactions with EDPs.

Recommendation to the Ministry of Community Safety and Correctional Services and Ontario Police College:

7. OPC is to receive and track statistics about frequency of edged weapon incidents in the field, police use of force, and how often a weapon is shown and/or deployed.

TRAINING & DEVELOPMENT

Recommendations to the Toronto Police Service and Ministry of Community Safety and Correctional Services:

8. The TPS and MCSCS shall consider, evaluate and implement strategies to maximize training opportunities for officers to be educated on the perspective of mental health consumers/survivors by:
    a. incorporating more information about consumer/survivors; and
    b. increasing opportunities for contact between officers and consumer/survivors.
9. Maximize emphasis on verbal de-escalation techniques in all aspects of police training at the Ontario Police College, at the annual in-service training program provided at Toronto Police College and at the TPS Divisional level.
10. With respect to situations involving EDPs in possession of an edged weapon:
    a. If the EDP has failed to respond to standard initial police commands (i.e. "Stop. Police.", "Police. Don't move.", and/or "Drop the Weapon."), train officers to stop shouting those commands and attempt different defusing communication strategies.
    b. Train officers in such situations to coordinate amongst themselves so that one officer takes the lead in communicating with the EDP and multiple officers are not all shouting commands.
11. Incorporate the facts and circumstances of each of these three deaths into scenario-based training. In particular, incorporate a neighbourhood foot pursuit of an EDP armed with an edged weapon, with several responding officers (not just two) to emphasize the importance of coordination, containment, and communication between the responding officers.
12. There should be mandatory annual trainer requalification for Use of Force trainers.
13. To achieve consistency, Sergeants should receive training to facilitate effective debriefing sessions.

Recommendations for the Ministry of Community Safety and Correctional Services, the Toronto Police Services Board, and the Toronto Police Service:

14. Train officers to, when feasible and consistent with officer and public safety, take into account whether a person is in crisis and all relevant information about his/her condition, and not just his/her behaviour, when encountering a person in crisis with a weapon.

15. Training officers on the subject of edged weapons shall incorporate the following principle:

    " When officers are dealing with a situation in which a person in crisis has an edged or other weapon, the officers should, when feasible and consistent with maintaining officer and public safety, try to communicate with the person by verbally offering the person help and understanding."

16. Officers must continue de-escalation attempts and refrain from firing as long as possible consistent with officer and public safety.

17. It should be emphasized and clarified in training that there is no fixed distance from a subject with an edged weapon at which officers should either draw or fire their firearms and that the reactionary gap (the time it takes to perform a response, which in this case would be the time it takes to discharge a firearm) is much shorter once a firearm is drawn.

Recommendations for the Toronto Police Services Board and the Toronto Police Service:

18. Provide additional mental health, verbal de-escalation, and negotiation training to officers including, but not limited to, PRU's and MCIT.

19. Evaluate the possibility of and consider having officers with the additional mental health and verbal de-escalation/negotiation training act as lead officers on calls involving persons in crisis.

20. With the understanding that debriefing is essential for driving continuous improvement and highlighting deviation from policy, the debriefing process for critical incidents should:
    a. be conducted in a timely manner
    b. be conducted effectively
    c. involve all subject and witness officers
    d. involve all active participants including call takers and dispatch personnel
    e. consider adoption of the ETF debriefing model
    f. be conducted by trained sergeants
    g. include video review when possible

Recommendations to Ministry of Community Safety and Correctional Services & Ontario Police College:

21. Modify the OPC EDP and de-escalation training model and materials, so that less attention is paid to specific diagnoses and the medical model. This should include input from consumer/survivors.

22. OPC to leverage/adopt the TPS format of using consumer/survivor videos to improve quality and achieve consistency in the delivery of EDP/Mental Health training.

Recommendation to Ontario Police College, Toronto Police Service, and Toronto Police College:

23. OPC and TPC shall consider expert review and analyses of videos, audios and evidence specific to each case, i.e. Sylvia Klibingaitis, Reyal Jardine-Douglas, Michael Eligon, for the purpose of identifying all alternative police service tactics for preserving life.

Recommendations to Ontario Police College and Toronto Police College:

24. Explore and consider opportunities for Training Sergeants to meet with subject officers for learning/training development (post-legal proceedings).

25. Consider providing officer with strategies to reduce immediate shock/adrenaline rush.

Recommendations for the Ministry of Community Safety and Correctional Services, Toronto Police Service, Ontario Police College, and Toronto Police College:

26. Incorporate more dynamic scenarios in use of force training (e.g. include bystanders, traffic, and distractions).

Recommendations to the Toronto Police Service:

27. With goal of increasing positive interactions between PRUs and the Mental Health community, develop an in-service learning exercise (e.g. drive along, MCIT shadowing, special day assignments, etc.) to increase PRU awareness and knowledge of the Mental Health community and resources.

EQUIPMENT/TOOLS/SYSTEMS

Recommendations for the Ministry of Community Safety and Correctional Services and Toronto Police Service:

28. Investigate and evaluate the adoption of improved equipment and alternative use of force measures for Primary Response Officers such as:
    a. body armour that provides officers greater protection from sharp-edged weapons
    b. body-worn camera technology for front line officers
    c. shields to disarm and control subjects with edged weapons

29. Study and evaluate the threshold for use of conducted energy weapons ("CEWs"). This evaluation shall include a public consultation component.

30. Where CEWs are available consider adopting the model with video option.

Recommendations to the Toronto Police Service:

31. Consider an improved, interoperable communication system between units/departments (TPS, EMS, ETF, Duty desk, etc.) towards the goal of reducing communication delays, errors and airway traffic. For example, the TPS dispatcher should not have to manually contact EMS by phone and verbalise critical information; an automated system would more effectively convey essential information.

32. Ensure that system "users" (e.g. dispatchers and trainers) are included as stakeholders when exploring new dispatch/call-taker tools and systems improvements.

MOBILE CRISIS INTERVENTION TEAM (MCIT)

Recommendations to the Toronto Police Service, Ministry of Health and Long Term Care, and Toronto Central Local Health Integration Network:

33. TPS to establish a permanent ongoing advisory committee to the MCIT with significant representation by consumer/survivors and Mental Health professionals to review and consider, among other things:
    a. Preferred Model (MCIT, CIT, Memphis, COAST, etc.)
    b. Service hours
    c. Policy and procedure
    d. Dispatch procedures
    e. Deployment of services
    f. Partnerships (support services, hospitals, community)
    g. Goals and performance

34. Expand availability of MCITs to make them available in all divisions of the City and to operate beyond their current 11 am – 9pm hours.

Recommendation to the Toronto Police Service:

35. Have officers who are current and former MCIT members wear a special insignia or badge to indicate to the community and fellow officers that they are past or present members of the MCIT.

POLICY/PROCESS

Recommendations to the Toronto Police Service:

36. Amend the TPS Communications EDP Procedure to require a Road Sergeant to be dispatched to a scene as soon as possible when the call involves an EDP with a weapon.
37. Implement procedures to improve communication regarding whether and when a Road Sergeant with a CEW is expected to attend a scene including the delivery of regular updates to officers regarding the Road Sergeant's estimated time of arrival at the scene when possible.
38. Establish a process to increase knowledge sharing and awareness through formalized information sessions/lectures to divisions by specialised units such as ETF, MCIT and Canine for all PRUs.
39. Amend TPS procedure documents to ensure it is clear that officers should not adopt a practice of handcuffing EDPs being apprehended under the *Mental Health Act* unless those individuals exhibit behaviour that warrants the use of handcuffs.
40. Incorporate guidance into the TPS Procedure on dealing with EDPs to encourage officers to, where feasible, bring an individual to a specific psychiatric facility where that individual is believed to have a prior relationship even when that facility is not the closest available facility in the City or division.
41. It is essential that the TPS ensures that all officers are aware of, and follow, current policies and procedures associated to SIU investigations.
42. Emphasize the importance of professionalism when personnel are communicating with each other including, but not limited to, the internal communication systems.

Recommendations for the Ministry of Community Safety and Correctional Services, the Toronto Police Services Board and the Toronto Police Service:

43. CEW training and policy should include information about risk of harm and death proximal to CEW use, in line with the manufacturer's documentation.

Recommendations for the Toronto Police Services Board and the Toronto Police Service:

44. Amend the current TPS procedure with respect to use of the in car camera systems (ICCS) to require officers to visually and audibly record:
    a. all investigative contacts with members of the public which are initiated from an ICCS equipped vehicle, **meaning investigative contacts initiated by the police from their ICCS equipped scout car. This would include, but is not limited to, traffic stops.**
    b. Crimes in progress that are taking place, **or might reasonably be expected to take place (in whole or in part)**, within viewing range of the ICCS.

    (The new clarifying language to be inserted in the existing procedure is bolded.)

Recommendation to Toronto Police Service & Empowerment Council:

45. TPS and the Empowerment Council should recognize officers who consistently perform exceptionally well at verbal de-escalation. This may include, but is not limited to accolades and letters of recommendation.

Recommendation to Toronto Police Service:

46. TPS, in collaboration with the SIU, shall explore ways to engage in ongoing dialogue with family members of the deceased / community members following a traumatic and tragic outcome in which the TPS are involved.

Recommendation to Ministry of Community Safety and Correctional Services, Ontario Police College, Toronto Police College, and Toronto Police Service:

47. Ensure that a process is in place to keep officers up-to-date regarding current standards for CPR – i.e. do not check for pulse and breathing, just perform compressions.

Recommendations to Toronto Police Service Corporate Planning:

48. Establish clear review cycles for policies, procedures, models, and other key documents (e.g. use of force model). Review cycles for policies referencing technology should be particularly frequent.

49. Establish a review process to ensure that written language in policies aligns to language used in training and practice. (e.g. Policy uses "apprehend," whereas Training uses "arrest")

COMMITTEE/CONSULTATION

Recommendation to be addressed to Ministry of Community Safety and Correctional Services:

50. Establish a committee or panel of mental health professionals and mental health consumer/survivors to review and provide feedback on current and future training materials used (including videos) that relate to mental health, EDPs, and persons in crisis.

Recommendation to be addressed to Toronto Police Services Board and Toronto Police Service:

51. Include in the Toronto Police Services Boards Mental Health Subcommittee representatives from advocacy organizations who support family members experienced with dealing with mental illness in their families in order to include their voice, knowledge, insights and perspectives.

PUBLIC EDUCATION/COMMUNITY RELATIONS

Recommendations to Toronto Police Service, Ministry Of Health and Long Term Care and the Local Health Integration Networks:

52. Create and implement better public awareness/education mechanisms about the crisis teams that do exist, and what resources are available to those in crisis and their families.

Recommendations to Toronto Police Service:

53. Improve public disclosure of goals/performance measures, especially where related to police use of force, to better facilitate community awareness and understanding of police responses in situations involving edged weapons. This would support an ongoing commitment to positive community relations and increase public confidence in 911 responses for EDPs in crisis.

Recommendations to be addressed to Toronto East General Hospital and Ontario Hospital Association for distribution to Ontario Emergency Departments:

54. Create spaces/environments within the emergency department that can reduce the risk of elopement. This may include locked units and procedures for monitoring patients (e.g. hired sitter or constant observation by nursing staff).

55. Consider the feasibility of creating a psychiatric waiting areas, away from the emergency area and building exits (e.g. a secure area for psychiatric patients who are admitted, when an inpatient bed is not yet available, or similarly, the model used in the Emergency Room at St. Joseph's Health Centre, Toronto), to reduce the risk for elopement.

56. To ensure that psychiatric patients (held on Form 1's or voluntary) are provided with timely support and as appropriate a clinical environment as possible in the circumstances, taking into account their reasons for being in crisis, the nature of their crisis, and their comfort.

57. To draft guidelines regarding early contact with the Hospital's crisis team (if one exists) when managing a patient in emotional crisis in the emergency department (once medically cleared) in order to assist in creating early linkages/support through the crisis program.

58. Ensure that the appropriate hospital emergency codes are activated and followed as per hospital policy (e.g. code yellow for missing patients, which would notify all parties and initiate the established procedures for elopements).

Recommendations to the Ministry Of Health and Long Term Care and the Local Health Integration Networks:

59. In collaboration with consumer/survivor groups, study evidence based support for use of peer support workers at all points within the continuum of care.

60. Collaborate with consumer/survivor groups to identify gaps in community support for improved management of mental health issues in the community (e.g. community integration/bridging programs).

61. To investigate the adequacy of urgent care psychiatric services (e.g. walk-in clinics, day programs) for patients who would not be treated in hospital emergency departments or could be more appropriately treated in the community. If access and/or supply of such services are found to be insufficient, consider increasing access and/or availability of such services.

62. Consider creating a provincial standard for spaces/environments within the emergency department that can reduce the risk of elopement.

63. Review security standards for hospitals, with special focus on practices related to Mental Health patients/care.

64. Increase funding and availability for more Mental Health case workers.

Recommendations to the Ontario Hospital Association:

65. When a patient is admitted to a psychiatric facility pursuant to a form under the *Mental Health Act*, the psychiatric facility shall ask the patient to provide a list of emergency contacts and shall request the patient's permission to inform those contacts that he/she has been admitted to the psychiatric facility pursuant to a form. If the patient's permission is granted, the psychiatric facility shall, as soon as practicable, inform those contacts that the patient has been admitted to the psychiatric facility pursuant to a form under the *Mental Health Act*.

66. When a patient is admitted either voluntarily or involuntarily to a psychiatric facility, the psychiatric facility shall ask the patient to provide a list of emergency contacts and shall request the patient's permission to disclose his/her medical information to those contacts. If the patient's permission to share his/her health information is granted, the psychiatric facility shall, as soon as practicable, inform those contacts if the patient's safety or security becomes a concern.

67. Upon acquiring a new client, a mental health case worker shall ask the client for a list of emergency contacts and permission to discuss his/her condition and circumstances with those contacts. If such permission is granted, the mental health case worker shall, as soon as practicable, inform those contacts if a client's safety or security becomes a concern or if the mental health case worker becomes aware that the client has been admitted to a psychiatric facility pursuant to a form under the *Mental Health Act*.

Recommendation to the Ontario Medical Association:

68. Upon acquiring a new patient, psychiatrists should ask the patient for a list of emergency contacts and permission to disclose his/her medical information to those contacts. If such permission is granted, the psychiatrist shall, as soon as practicable, inform those contacts if the patient's safety or security becomes a concern or if the psychiatrist becomes aware that the patient has been admitted to a psychiatric facility pursuant to a form under the *Mental Health Act*.

Recommendation to the Ministry Of Health and Long Term Care, Ontario Medical Association, and Toronto Police Service:

69. Establish a communication process to allow officers to check for hospital availability when apprehending a patient under the *Mental Health Act*.

Recommendation to the Ministry Of Health and Long Term Care, the Local Health Integration Networks, and the United Health Network:

70. In support of family and care givers, consider increasing the availability of and funding for programs providing mental health "first aid" education in terms of first responses or initial steps to seeking assistance/care for persons developing a mental health problem or experiencing a mental health crisis.

COMMUNITY RELATIONS & PUBLIC EDUCATION

Recommendations to the Ministry of Health and Long Term Care:

71. Encourage increased public education and awareness about the current standard for the application of chest compressions while waiting for emergency responders.

72. An increase in advertising campaigns to promote greater public awareness of the availability of mental health crisis hotlines and services in Ontario and an increase in funds be made available for enhancing mental health helplines and accessible services in Ontario.

Recommendations to the Office of the Chief Coroner:

73. Compile and maintain a searchable repository containing facts, jury recommendations, and any responses received thereto arising from prior and future Coroner's Inquests in Ontario.

Recommendation to Ministry of Municipal Affairs & Housing, Empowerment Council, Mental Health Service Providers, and Local Health Integration Networks:

74. Provide further funding to expand community resources with Mental Health crisis support. For example the Gerstein Centre, COTA, etc.

-End-

Office of the Chief Coroner
Bureau du coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

We the undersigned / Nous soussignés,

[redacted] of / de Toronto, Ontario
[redacted] of / de Toronto, Ontario
[redacted] of / de Toronto, Ontario
[redacted] of / de Toronto, Ontario
[redacted] of / de Toronto, Ontario

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de :

Surname / Nom de famile	Given Names / Prénoms
McGillivary	Charles

aged / à l'âge de 45 held at / tenue à Toronto, Ontario

from the / du 3rd February to the / au 27th February 20 14

By / Par Dr. / Dr Dan Cass Coroner for Ontario / coroner pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit :

Name of Deceased / Nom du défunt
Charles McGillivary

Date and Time of Death / Date et heure du décès
August 1, 2011 at 20:59 hours

Place of Death / Lieu du décès
Toronto Western Hospital, 399 Bathurst Street, Toronto, Ontario

Cause of Death / Cause du décès
Cardiac arrhythmia precipitated by struggle and restraint in the context of multiple medical conditions, including catecholaminergic polymorphic ventricular tachycardia.

By what means / Circonstances du décès
Accident

Original signed by: Foreperson / Original signé par : Président du jury

Original signed by jurors / Original signé par les jurés

The verdict was received on the / Ce verdict a été reçu le 27th (Day / Jour) day of / February (Month / Mois) 20 14

Coroner's Name.(Please print) / Nom du coroner (en lettres moulées)	Date Signed (yyyy/mm/dd) / Date de la signature (aaaa/mm/dd)
Dr. Dan Cass	2014/02/27

Coroner's Signature / Signature du coroner

Office of the
Chief Coroner

Bureau du
coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Inquest into the death of:
Enquête sur le décès de :

Charles McGillivary

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

We, the jury, wish to make the following recommendations:

To Toronto Police Service ("TPS"):

1. Equip all Toronto Police Services primary response scout cars and supervisor vehicles with automatic external defibrillators (AEDs).

2. Amend Procedure 01-03, section 6 to clarify that a police officer has an obligation to provide cardiopulmonary resuscitation (whether hands-only or hands and mouth breaths), not just "first aid", in accordance with the member's training, when a person in custody requires medical attention due to illness, injury or intoxication.

3. Equip every front line officer with mouth shields and gloves so they can perform CPR and mouth-to-mouth resuscitation.

4. Amend TPS Procedure 04-09 to include:

    a. guidance for officers trying to determine if a subject is not communicating because of medical and /or cognitive disability, and

    b. guidelines for officers in terms of best practices and resources available to them when interacting with persons who have difficulty communicating for reason of a medical condition and/or cognitive disability. Such guidelines should set out the roles that support persons, Duty Desk, Communications and Mobile Crisis Intervention Teams may play in such situations.

5. Use both metric and imperial measurements when recording physical descriptors (example e.g. height and weight) across all record systems.

6. Enhance the Chief of Police's "Section 11 Reports" to the Toronto Police Services Board so as to include a "quality improvement" section that outlines possible areas of improvement for procedures and/or training arising out of the Section 11 review.

To The Ministry of Community Safety and Correctional Services ("MCSCS"):

7. Review the timing of the removal of identifiers from any report. If removal of identifiers is appropriate, do so upon the completion of all legal proceedings.

To Ontario Police College ("OPC"), the Ministry of Community Safety and Correctional Services ("MCSCS") and Toronto Police Service ("TPS"):

8. Study the incorporation of dynamic, scenario-based training that involves officers practicing ground pins against resisting subject when paired with a partner.

