Verdict Explanation

Reyal Jardine-Douglas
Sylvia Klibingaitis
Michael Eligon, Jr.

October 15, 2013 – February 12, 2014
Coroner's Courts
Forensic Sciences and Coroner's Complex
25 Morton Shulman Ave., Toronto

Opening comment:

I intend to give a brief synopsis of issues presented at this inquest. I would like to stress that much of this explanation will be my interpretation of both the evidence presented and of the jury's reasoning in making recommendations. The sole purpose of this explanation is to assist the reader in understanding the verdict and recommendations made by the jury. This explanation is not to be considered as actual evidence presented at the inquest and is in no way intended to replace the jury's verdict.

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Overview of the Inquest

A joint inquest was ordered by the Chief Coroner into the deaths of Mr. Reyal Jardine-Douglas, Ms. Sylvia Klibingaitis, and Mr. Michael Eligon. All three sustained fatal gunshot wounds after approaching a police officer while armed with an edged weapon, and apparently under the influence of a mental illness. Inquests into the deaths were mandatory under Subsection 10(4.6) of the *Coroners Act*. The inquest began hearing evidence on October 15, 2013. The jury heard from 78 witnesses during 39 days of evidence, and 79 exhibits were filed. The jury returned its verdict and recommendations on February 12, 2014.

The inquest heard evidence about the circumstances of each of the three deaths, and the prevention of future deaths in similar circumstances. This included, but was not limited to;

- current state of knowledge
- available strategies, and
- police policies and training

relating to the;

- identification and management of persons who represent a potential risk on the basis of mental disorder, and
- response to potential risks presented by a person armed with an edged weapon.

Circumstances surrounding the death of Mr. Jardine-Douglas

Mr. Jardine-Douglas, aged 25 years, had experienced increasing withdrawal and other symptoms in the approximately 2 years preceding his death. Previously well physically, psychologically, and socially, he had become increasingly isolated and prone to disturbing thoughts. His family, with whom he lived, became more and more concerned for his well-being. He initially resisted their efforts to encourage him to discuss his symptoms with a physician, but reluctantly agreed to do so.

He was assessed by his family physician on August 27, 2010. His physician confirmed the family's concern that Mr. Jardine-Douglas had a serious mental illness, and initiated an urgent psychiatric referral. The physician did not find evidence that Mr. Jardine-Douglas was dangerous to himself or others at that time.

Early the following morning (August 28), concerned about his increasing symptoms, Mr. Jardine-Douglas' mother brought him to the Emergency Room of Scarborough Centenary Hospital, from which he was referred to Scarborough Grace Hospital. He left that hospital before being assessed. At that time, he did not have symptoms that met the legal test for involuntary hospitalisation (such as dangerousness to himself or others), and was free to leave if he wished.

On August 29, Mr. Jardine-Douglas' mother and sister became even more concerned about his behaviour and the possibility of dangerousness to self or others. He tried to drive away in his mother's car, but his sister and mother prevented him from doing so. He then boarded a TTC bus. His sister called 9-1-1 and explained her concerns to the call-taker. She reported that Mr. Jardine-Douglas was carrying a backpack, and she was unable to exclude the possibility he had a weapon.

The bus was stopped by two police cruisers. The events were recorded on bus surveillance video. Mr. Jardine-Douglas attempted to leave the bus by the rear door, but could not open the door because of a safety interlock. He returned to his seat. The officers began to board from the front of the bus. He then removed a knife from his backpack and advanced on the officers.

The officers gave and repeated the police challenge, telling Mr. Jardine-Douglas to "freeze" and "drop the knife." They retreated from the bus and drew their firearms. Mr. Jardine-Douglas followed the officers off the bus. The officers split and went in two different directions. Mr. Jardine-Douglas continued to advance on one of the officers. The officer changed direction more than once to open the space between Mr. Jardine-Douglas and himself, but Mr. Jardine-Douglas also changed direction and continued to close the distance with the officer. The officer ended up against a hedge from which further retreat was not feasible, with Mr. Jardine-Douglas continuing to advance with the knife.

The officer fired his weapon. Mr. Jardine-Douglas fell to the ground. He was still conscious, did not comply with demands to drop the weapon, and attempted to get up. The officer fired another shot, at which point he stopped moving. The officers approached him, found and kicked away the knife, then started CPR. Paramedics arrived shortly afterwards, and found Mr. Jardine-

Douglas without vital signs. He was transported to Sunnybrook Health Sciences Centre, where he was pronounced dead after resuscitation efforts.

The death was investigated by the coroner. Autopsy showed two gunshot wounds: one entering the left shoulder and going into the chest, the other entering the right hip from the front. In the opinion of the forensic pathologist, the most likely sequence of events was that Mr. Jardine-Douglas sustained the gunshot wound to his hip, fell to the ground, and was attempting to get up again when he was struck by the second and fatal bullet in his left shoulder.

The death was investigated by the Special Investigations Unit (SIU). No criminal charges were laid.

Circumstances surrounding the death of Ms. Klibingaitis

Ms. Klibingaitis, aged 52 years, had a history of mental illness, for which she had sought treatment and was under psychiatric care. The course of her illness varied over time. Her symptoms included delusions that she was evil, and that God had singled her out for punishment. She lived with her elderly mother in a detached family home in a residential neighbourhood in Toronto. Family, including her three sisters, were supportive and helpful. She had no history of violence or dangerousness to others prior to the day of her death.

On October 7, 2011, a little after 9:30 a.m., Ms. Klibingaitis made a call to 9-1-1 from her residence, stating that she was holding a knife, and intended to kill her mother, who was in the bathroom of the residence. The 9-1-1 operator dispatched police, and then asked Ms. Klibingaitis to put the knife down. Ms. Klibingaitis refused.

Two uniformed officers arrived at the scene in marked police vehicles. They separated after performing an inspection of the perimeter of the house. Ms. Klibingaitis, holding a large knife, ran out of the front door towards the officer who was at the front of the house. He retreated, unholstered and pointed his firearm at her, and issued the police challenge. She continued to advance while he ran backwards onto the street with Ms. Klibingaitis following him. The cruiser's video camera captured the officer running backwards past the front of the cruiser, with Ms. Klibingaitis following him with a knife held at shoulder level. He shot her, and she collapsed onto the middle of the street. The shooting occurred outside the camera's field of view.

The officers kicked away her knife and provided first aid. Paramedics arrived shortly after, and found Ms. Klibingaitis without vital signs. She was transported to Sunnybrook Health Sciences Centre, where she was pronounced dead after resuscitation efforts.

The coroner was notified and investigated the death. Autopsy showed that death was due to perforating gunshot wound of the chest.

The death was investigated by the SIU. No criminal charges were laid.

Circumstances surrounding the death of Mr. Eligon

Mr. Michael Eligon, Jr., aged 29 years, had a history of mental illness, for which he had sought treatment and had been under psychiatric care. The course of his illness varied over time. His symptoms included auditory and visual hallucinations. He lived on his own, and had moved several times prior to his death. He was living in a supportive residential environment at the time his death. A mental health case worker coordinated his care. He had no history of violence or dangerousness to others prior to the day of his death.

On February 1st, 2012, workers from Mr. Eligon's residence contacted police because he was acting in an unusual manner. Police responded, and found him confused, hostile, argumentative, and agitated. They agreed with his workers that he appeared to be experiencing an exacerbation of his mental illness that put him at risk, and took him to the Emergency Room of Toronto East General Hospital (TEGH) for assessment. He had previously received inpatient and outpatient care at St. Joseph's Health Centre but his residence was closer to TEGH.

He was assessed by the Emergency Room physician at about 10:00 p.m., and was admitted as a psychiatric inpatient. No inpatient bed was immediately available, and he was held in the Emergency Room. During the following nearly 36 hours, Mr. Eligon was cooperative, but, early in the morning of February 3rd he started to become increasingly agitated. At approximately 9:55 am on February 3, Mr. Eligon surreptitiously left his room and exited the hospital via a side door, wearing his hospital gown. Emergency Room staff noticed that he was missing and notified hospital security, who began a search of the hospital and grounds.

Mr. Eligon left the hospital grounds and entered a variety store near the hospital, removed 2 pairs of scissors from a wall display, and left without paying. The store owner went outside after him, and asked him either to pay or return the scissors. Mr. Eligon voluntarily returned into the store. After a brief discussion, the two scuffled, and the owner was injured with the scissors. It is not known whether Mr. Eligon intended to inflict the injuries with the scissors, or if the cuts occurred because he was holding the scissors in his hands during the scuffle. The store owner opted not to follow him out of the store, and called 9-1-1 to report the theft and the injury. He provided a description of Mr. Eligon. Police and ambulance were dispatched.

Mr. Eligon then successively approached two women near their cars, requesting their car keys. Both refused, and reported the events to police.

Mr. Eligon attempted to enter a family home through its back door. The husband, who was outside, told him to leave, and the wife, who was indoors, called 9-1-1. Other civilian witnesses saw the events, some of whom had some minor interaction with Mr. Eligon. All suspected mental illness from his confused behaviour and speech, and from the fact that he was outdoors in February dressed only in a hospital gown. Many saw that he was carrying 2 pairs of scissors.

A number of police units responded to the multiple 9-1-1 calls. Mr. Eligon was located, and officers began to converge on him. Mr. Eligon began to advance on the officers, holding the scissors. The officers retreated down the street, walking backwards, and issued the police challenge. A number of them unholstered and pointed their firearms. The final portion of the incident was captured on the video camera of a parked police car. Mr. Eligon did not comply

with the police challenge, and advanced towards the officers, who continued to retreat down the street. One officer backed into a parked vehicle, and did not have a clear escape route. Mr. Eligon continued advancing to within a few feet. At that point, an adjacent officer shot Mr. Eligon, who fell to the ground. Officers kicked away the scissors then provided first aid. Paramedics arrived shortly after, and found Mr. Eligon without vital signs. He was transported to St. Michael's Hospital, where he was pronounced dead after resuscitation efforts.

The coroner was notified and investigated the death. Autopsy showed that death was due to penetrating gunshot wound of the neck.

The death was investigated by the SIU. No criminal charges were laid.

Expert Psychiatric Evidence

An independent expert in psychiatry provided opinion evidence to the jury. The expert's opinion was that the acute escalation of symptoms, associated with serious dangerousness to others, could not reasonably have been predicted in any of the three cases. In the case of Michael Eligon, the lethal interaction with police may have been preventable if he had not been able to leave the hospital. This could have been achieved by earlier admission to a secure inpatient psychiatric unit, or by holding him in a secure setting with more monitoring while in the Emergency Room.

VERDICT OF JURY

The jury made the following findings:

Name of Deceased:	**Reyal Jardine-Douglas**
Date and Time of Death:	**August 29, 2010 at 16:07**
Place of Death:	**Sunnybrook Health Sciences Centre, Toronto**
Cause of Death:	**Penetrating Gunshot wound to the left shoulder**
By what means:	**Homicide**

Name of Deceased:	**Sylvia Klibingaitis**
Date and Time of Death:	**October 7, 2011 at 10:26**
Place of Death:	**Sunnybrook Health Sciences Centre, Toronto**
Cause of Death:	**Perforating gunshot wound of chest**
By what means:	**Homicide**

Name of Deceased:	**Michael Eligon**
Date and Time of Death:	**February 3, 2012 at 10:37**
Place of Death:	**St. Michael's Hospital, Toronto**
Cause of Death:	**Penetrating gunshot wound to right side of neck**
By what means:	**Homicide**

JURY RECOMMENDATIONS

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.

Coroner's Comment: There is currently limited formal follow-up, research or study about the extent to which officers actually apply their training when a situation arises in real life. Structured collection of information would assist in the improvement of training.

Recommendations 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.

Coroner's Comment: Persons with serious mental illness are more likely than the general population to face CEW use during police interactions.

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.

Coroner's Comment: There are jurisdictions, such as the United Kingdom, in which some police officers do not carry firearms. The jury encouraged research into procedures used by such jurisdictions, to look for potentially useful strategies for police response to edged weapons in Ontario.

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.

Coroner's Comment: Use of force by police officers in Ontario is governed by the Ontario Use-of-Force Model (OUFM). Incidents of use-of-force are documented on a standard form.

The Ontario Use-of-Force Model guides officers in determining when and how force should be used in the wide variety of situations in which it may be a consideration. Police may use a wide range of options which include but are not limited to verbal communication, open hand techniques, baton, pepper spray, CEW, and firearms.

The model guides the officer in how to make a decision, rather than specifying what the officer's decision should be. The officer must continuously reassess the situation, and change response in a flexible and effective manner. The model encourages alternatives to use-of-force, including tactical communication and disengagement. The most effective and safest response depends on a large number of factors which go beyond the behaviour to which the officer is responding, including but not limited to the environment, the number of officers present, the number and proximity of bystanders, the physical size and skills of the officer, and equipment immediately available to the officer.

The model encourages "tactical communication," in which the police officer may de-escalate a situation by engaging the person in conversation, addressing the person's fears, and providing reassurance and comfort. Testimony from police trainers suggested that this more calming form of communication is not an option where the actions of the assailant create an immediate risk of death or serious injury. At such times, the "police challenge," a firm and loud command, is used.

The form for reporting use-of-force has not been updated in some time, is paper-based, and does not contain specific questions about CEW use, mental illness, or tactical communication. Electronic collection of richer information about use-of-force would facilitate better analysis, and assist in determining which strategies are most effective when used by police during critical interactions. See also Coroner's Comment under Recommendation 7.

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

Coroner's Comment: See Coroner's Comment under Recommendation 4.

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.

Coroner's Comment: By reason of its high population, single police service, and community and academic resources, Toronto is in a unique position to host potentially valuable research into police interactions with persons with mental illness. The interests of persons with mental illness who interact with police officers were represented at the inquest by the Empowerment Council.

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.

Coroner's Comment: Collection of this information and analysis of provincial use-of-force reports would assist in determining the frequency of edged-weapon incidents, and the safest and most effective police response.

A number of witnesses testified that persons often de-escalate their behaviour when an officer unholsters a CEW (i.e. without discharging it). While information is mandatorily collected when a CEW is discharged, there is no consistent collection of data when a CEW is displayed but not fired. Because display alone appears to be an effective tactic, structured collection of information in such incidents would assist in improvement of policy and training.

This Recommendation is complementary to, but not dependent upon, Recommendations 4 and 5 (enhanced data collection on use-of-force).

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.

Coroner's Comment: Police training currently includes modules on interactions with persons with mental illness, which include videos of persons who have had interactions with police, both positive and negative, while experiencing a mental health or emotional crisis. Witnesses recommended greater focus on such interactions during police training, including personal attendance by such persons at police training sessions.

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.

Coroner's Comment: There was clear and undisputed evidence that verbal interaction is highly effective in de-escalating the vast majority of interactions, and should be the preferred approach. However, the teaching of verbal de-escalation techniques to police varies, and therefore, there is an opportunity to improve quality and consistency of verbal de-escalation techniques by increased standardisation of training.

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.

Coroner's comment: A person who is a state of psychosis due to mental illness may have trouble understanding commands and relating to others. Provided that time and circumstances allow, and that it is safe for the officer and others, use of a quieter tone of voice and a more engaging approach may be an option.

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.

Coroner's Comment: In the case of Mr. Eligon, a number of officers were simultaneously shouting commands. Since Mr. Eligon's mental illness affected his ability to understand reality, the simultaneous commands from many officers may have been difficult for him to process and respond to. The jury recommended that a single officer give the police challenge, to assist a person with acute mental disorder to understand and respond.

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.

Coroner's Comment: The officers involved in these incidents testified about the challenges of rapid decision-making and coordination among officers during a critical situation.

12. There should be mandatory annual trainer requalification for Use of Force trainers.

Coroner's Comment: All police officers are required to take annual use-of-force training under the supervision of a qualified instructor, but those instructors are not currently required to requalify annually. After hearing mixed evidence about optimal training requirements for instructors; the jury chose to recommend annual requalification.

13. To achieve consistency, Sergeants should receive training to facilitate effective debriefing sessions.

Coroner's Comment: Debriefing after a critical incident can be useful in gathering information which will improve future police interactions. The jury recommended increasing standardisation of debriefing, based upon evidence that the information would be collected in a uniform way which will assist in analysis and application.

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.

Coroner's Comment: The jury heard detailed evidence about how officers are trained to respond to an edged weapon.

An edged weapon wound carries a high risk of serious injury or death, even against a person with advanced martial arts training. The best way to avoid injury from a person armed with an edged weapon is to maintain adequate distance from the person, while taking advantage of available cover. Retreat is an option, but carries risks. Running backwards allows the officer to monitor the person, but increases the risk of a fall (with increased vulnerability to attack, and risk of dropping or unintended discharge of a firearm). On the other hand, retreating by turning away from an assailant opens the officer to an attack from the back and puts nearby onlookers at risk from the assailant.

Open hand techniques or batons are considered ineffective and inappropriate against an attacker armed with an edged weapon, unless no other options are available. For instance, if a firearm jams, an officer might use a baton while attempting to clear the weapon. Kicking an edged weapon out of the attacker's hand during active assault (a technique used on TV and movies) is ineffective in real life. Police officers are trained to kick edged weapons away from attackers after the attackers are disabled by gunshots, but not to defend themselves during the attack by kicking at the knife. 'Pepper spray' also is usually not practical or effective against attack with an edged weapon. CEW is not a recommended use-of-force option against an edged weapon, except in very limited circumstances, and would involve a minimum of 2 police officers.

When a person approaches with an edged weapon, police are trained to;

- *issue firm, repeated commands to stop advancing and drop the weapon,*
- *retreat to the extent that it is safe to do so,*
- *un-holster and aim their firearm, and*
- *discharge the firearm at the 'centre of mass', i.e. the chest or torso, if the assailant approaches within a distance and is acting in such a way that the officer believes will cause death or serious harm..*

Disabling the attacker by firing the gun at an arm or leg, or shooting the knife out of someone's hand (both tactics used in TV and movies), are not feasible options in real-life situations, even for the most experienced and skilled operator.

Police are trained to continue firing until the threat has stopped, because;

- *shots frequently miss the target, even when fired at close-range, and,*
- *even if struck by a bullet, a person may remain a threat, at least temporarily, because bullet wounds may not always immediately incapacitate a person.*

*Once a police officer or a bystander is at serious risk of actual harm from a person armed with an edged weapon, the police officer is trained to respond to the person's **behaviour** (the potential for imminent use of the edged weapon), rather than the person's **condition**, (e.g. whether or not the person's threatening behaviour is due to mental illness). There was mixed evidence about the extent, if any, to which police should (or even can, given how quickly events can unfold, and that police are not health professionals) be trained to assess and take into account the presence of mental illness when responding to a person with an edged weapon. Once an attacker is close to the officer and wielding an edged weapon, undue delay in use of force by police can result in increased risk of preventable death or serious harm to the officer or others. The jury recommended taking the presence of mental illness into account, but only if the safety of officers and bystanders is not compromised.*

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."

Coroner's Comment: The jury heard that critical interactions unfold at different paces and, when there is adequate time available, an alternative to the police challenge and use of a firearm may be feasible. See also Coroner's Comments under Recommendations 10,11 and 14.

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

Coroner's Comment: See Coroner's Comment under Recommendation 14.

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.

Coroner's Comment: Police are trained that a person, armed with an edged weapon and at a distance of about 21 feet (approximately 6.5 m), can reach the officer and inflict a lethal wound in less time than it takes for an officer to assess the situation, draw a firearm and discharge it. Police trainers testified that officers should be conscious of this, and recognize that a person armed with an edged weapon and at or within 21 feet represents a potential lethal threat. Once a person with an edged weapon is within 21 feet, risk increases as the person approaches closer

to the officer. In contrast, some officers appeared to understand that there was an abrupt increase in danger the moment a person was 21 feet away.

The 21 foot distance applies when an officer's weapon is holstered. If the officer has already drawn the firearm, then the officer can respond more quickly ("reactionary gap"), and the safe distance may be less than 21 feet.

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.

Coroner's Comment: A number of witnesses endorsed this recommendation that this training, which is currently delivered to specialised units, should be made more available to primary responders and MCIT's.

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.

Coroner's Comment: Because of its size, the Toronto Police Service has a significant number of officers on duty at any given time with additional experience and training in dealings with persons with mental illness. The jury suggested that, where possible, efforts be made to assign those officers to act as first responders on EDP calls.

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

Coroner's Comment: The ETF has a structured debriefing model which the jury encouraged be more widely used within the police service. As well, the current debriefing model may not routinely include call-takers. The interactions of call-takers with both callers and dispatched officers was important in all three of the deaths.

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.

Coroner's Comment: Police officers are not, by their role and training, positioned to diagnose specific mental illness. Training on mental illness should be practical and as relevant as possible to the knowledge, skills and role of police officers. It should take into account input of persons with mental illness who have had interactions with police may be of assistance. Police training on mental illness is also the subject of Recommendation 14.

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.

Coroner's Comment: Self-explanatory.

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.

Coroner's Comment: A number of witnesses commented on the potential value of analysis of these cases.

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).

Coroner's Comment: This was supported by a number of witnesses. Criminal or other matters arising from a critical incident may necessarily delay debriefing and other procedures for improving quality.

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

Coroner's Comment: There was consistent evidence from the involved officers and other witnesses that, during a critical interaction such as the ones resulting in these deaths, police officers must make vital decisions under immense time pressure, while at risk of personal harm or death, and during intense physical exertion. This unusual and stressful set of circumstances is currently simulated during present training, and the jury recommended further enhancement of strategies to prepare officers for critical incidents.

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).

Coroner's Comment: The police officers directly involved in the deaths spoke to the number of factors that they had to take into account in deciding their actions. These factors complicate decision-making. Practice with mixed presentation of multiple factors during training may assist officers during actual critical incidents.

Recommendations to the Toronto Police Service:

27. With the 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.

Coroner's Comment: This recommendation dovetails with Recommendation # 8 above.

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

Coroner's Comment: Currently available body armour is more effective against bullets than edged weapons, and provides no protection to other vulnerable areas of the body such as head, neck and legs. Body-worn cameras are a new technology, with substantial advantages and disadvantages which must be balanced. Issues with adoption include legal issues (such as privacy inside a residence or the face of an uninvolved person), resources (significant) and other factors. Similarly, while shields are too large and cumbersome to be carried routinely, shields can be effective in limited circumstances, if physically available to officers who have appropriate training and experience. The jury recommended continuing study of these options with adoption where appropriate.

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

Coroner's Comment: The inquest heard evidence about the limited value of CEW use in the specific circumstances of these deaths. The vast majority of CEW deployments occur in other circumstances, to which very different considerations apply. The two much broader policy issues of the threshold for use of CEWs in every situation, and the most appropriate distribution of CEWs to police officers, were not examined in detail at the inquest. The jury recommended further study and consultation.

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

Coroner's Comment: Certain CEW models capture video when activated, which can be useful in reviewing the interaction afterwards.

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.

Coroner's Comment: Self-explanatory.

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

Coroner's Comment: Self-explanatory.

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

Coroner's Comment: The jury heard evidence that there are a number of models for specialised police response to EDP calls. The best delivery model for a specific locality depends, among other things, on resources available and the type of population served.

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.

Coroner's Comment: Evidence was heard that, because continuous coverage of all areas of Toronto is not possible within currently assigned resources, the MCIT teams are scheduled during peak call times and in the areas of Toronto in which the resources (which include hospital staff) are available. The TPS is making efforts, in cooperation with other stakeholders, to provide MCIT teams throughout all of Toronto, and during longer 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.

Coroner's Comment: This would assist other officers and members of the public in identifying officers with specialised training and experience.

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.

Coroner's Comment: In the Eligon case, a ranking officer was not present on scene prior to the shooting, and it is possible that such an officer, if present, would have been able to coordinate the response of officers to a greater extent than actually occurred. Furthermore, at the time of the deaths and at present, road sergeants carry CEWs, which may represent a less-lethal option than a firearm in certain circumstances.

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.

Coroner's Comment: In the Eligon case, some officers on the scene were awaiting the arrival on-scene of an officer with a CEW, but were not sure when the officer would arrive. The shooting occurred before the arrival of a CEW-equipped officer.

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.

Coroner's Comment: This would improve knowledge of primary responders concerning the role and value of specialized police units.

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.

Coroner's Comment: Mr. Eligon remained handcuffed while in the Emergency Room awaiting assessment. He said that the handcuffs were uncomfortable, and asked for them to be removed. The officer opted not to remove them. Both the physical discomfort, and the fact that he was wearing handcuffs while visible to members of the public, may have increased Mr. Eligon's stress. Taking into account all of the circumstances, it was not clear whether handcuffing was necessary at that time in the interests of safety of Mr. Eligon and others. The jury recommended that the decision about handcuffing be made based upon the officer's assessment of the person's dangerousness, rather than as routine procedure.

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.

Coroner's Comment: Mr. Eligon had received his prior inpatient and outpatient psychiatric care at St. Joseph's Health Centre, a facility that he was familiar with and where staff knew him. He was taken to Toronto East General Hospital, which was the closest facility. Proximity is one of a

number of factors police take into account in deciding which hospital to take a person apprehended under the Mental Health Act. The jury recommended that prior care at a particular hospital be given greater weight when police are making this decision. See also Recommendation 69 for factors to be taken into account in this decision.

41. It is essential that the TPS ensures that all officers are aware of, and follow, current policies and procedures associated to SIU investigations.

Coroner's Comment: Following one of the shootings, a witness officer and subject officer were alone in a police cruiser unsupervised. This is contrary to investigative rules which require involved officers to be sequestered immediately, in order to protect the independence of each officer's evidence.

42. Emphasize the importance of professionalism when personnel are communicating with each other including, but not limited to, the internal communication systems.

Coroner's Comment: Audio of communication within the police service (i.e. not with the public or other agencies such as ambulance) included comments which were casual and possibly inappropriate.

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.

Coroner's Comment: Deaths have occurred in rare cases after CEW use. The extent, if any, to which CEW contributed to these deaths is uncertain and controversial. Based on current scientific knowledge, it is possible, but not proven, that there is a low but real risk of death caused by CEW use. Police officers should be provided with the most accurate and up-to-date information about CEW risks when taking CEW training.

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.)

Coroner's Comment: The policy, as currently worded and explained to officers, is subject to different interpretations which may result in different actions by officers in the same circumstances. The jury recommended that the policy be clarified so that it will be more understandable and more consistently implemented by officers. In addition to the recommendation for clarification, the jury provided its recommendation on what the policy should require.

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.

Coroner's Comment: Verbal de-escalation by police officers is a useful skill which improves public safety, and should be recognized.

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.

Coroner's Comment: Communication among family, SIU and the police service is limited during an SIU investigation, due to the legal requirements of a criminal investigation. This can increase the grief of family members. The jury recommended optimising the timing and content of

communication with families, taking into account the requirements of criminal or other investigations.

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.

Coroner's Comment: The jury heard evidence from an expert witness about current best practices for when and how CPR should be performed. Some police witnesses had a different understanding, and this recommendation was directed to ensuring that officers are up to date in CPR provision.

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.

Coroner's Comment: Self-explanatory.

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")

Coroner's Comment: Self-explanatory.

COMMITTEE/CONSULTATION

Recommendation 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.

Coroner's Comment: The jury encouraged that design of use-of-force training should take into account the perspectives of mental health professionals, and persons with mental illness who have had contact with police.

Recommendation 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.

Coroner's Comment: Families provide key, day-to-day support for many persons with mental illness. They can offer a valuable perspective for policymakers.

PUBLIC EDUCATION/COMMUNITY RELATIONS

Recommendations to Toronto Police Service:

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.

Coroner's Comment: There is limited knowledge among members of the public about the availability of police and other resources to assist persons experiencing a mental health crisis.

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.

Coroner's Comment: The jury heard that the public currently receives little overall information about the use of force by police officers, and that police services are not routinely setting public, objective targets or benchmarks for use-of-force interventions. This recommendation calls for police to publicly set goals, and report progress toward those goals.

HEALTHCARE

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).

Coroner's Comment: The jury heard that elopements of psychiatric patients from Emergency Rooms are a common event, and that the risk can be substantially reduced by provision of secure waiting areas and/or structured, continuous monitoring of such patients.

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.

Coroner's Comment: See Coroner's Comment under Recommendation 54.

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.

Coroner's Comment: Mr. Eligon had been held in the Emergency Room for almost 36 hours before he eloped. By its nature, an Emergency Room is a busy, noisy environment which is not ideal for a person experiencing a mental health crisis. A psychiatric ward provides a therapeutic environment.

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.

Coroner's Comment: Like the previous one, this recommendation emphasizes assigning priority to psychiatric patients in the Emergency Room.

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).

Coroner's Comment: While there was an immediate and concerted response to the discovery that Mr. Eligon had eloped, the response was not entirely consistent with hospital procedures.

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.

Coroner's Comment: A person in mental health crisis may benefit from the assistance of a peer support worker, that is, a non-health professional who has experienced mental health care, and can guide and assure the patient.

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).

Coroner's Comment: Many psychiatric patients can benefit substantially from community and other programs after discharge from hospital, but those resources are limited and often not available.

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.

Coroner's Comment: Urgent psychiatric services provided other than through Emergency Rooms are more effective and efficient to assist some, but not all, persons in crisis, so expanding their availability could improve care.

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

Coroner's Comment: There is not currently a provincial standard. Individual hospitals make the decision based on their psychiatric case volume, taking into account resources and other factors including competing priorities. Given how common elopements are, and the potential consequences, a provincial standard would improve consistency of care and reduce elopements and their resulting harm.

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

Coroner's Comment: See Coroner's Comment under Recommendation 62.

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

Coroner's Comment: A Mental Health case worker is a professional who coordinates care and liaises with the patient on an ongoing basis. The result is an ongoing therapeutic relationship which assists the patient with community integration.

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*.

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*.

Coroner's Comment: In recommendations 65-68, while respecting the rights of psychiatric patients to make treatment decisions including information release, the jury encouraged facilitating family involvement in care.

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*.

Coroner's Comment: Wait times for assessment and admission may vary among hospitals at any given time. This recommendation is complementary to Recommendation 40 as a factor to be taken into account by police in selecting a hospital.

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.

Coroner's Comment: See also Recommendation 61 above. Witnesses testified that, where possible, earlier care by a health professional, perhaps facilitated by a family member, was better than apprehension by police and assessment in an Emergency Room. The jury recommended increased public education about earlier treatment options.

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.

Coroner's Comment: See Coroner's Comment under Recommendation 47 above.

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.

Coroner's Comment: See Coroner's Comment under Recommendation 70 above.

OTHER

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.

Coroner's Comment: Such a publicly searchable repository or resource would assist in the analysis of inquest jury recommendations and responses by agencies.

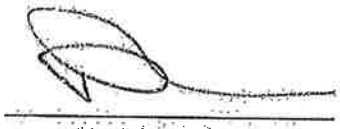
Recommendation to Ministry of Municipal Affairs & Housing, Empowerment Council, Mental Health Service Providers, and Local Health Integration Networks:

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

Coroner's Comment: The jury heard evidence about the two facilities mentioned in the recommendation, which provide supported residential accommodation for persons with serious mental illness. The jury recommended further funding for these and similar facilities.

Closing comment:

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury verdict. It is worth repeating that this is not the verdict. Likewise, many of the comments regarding the evidence are my personal recollection of the same and are not put forth as actual evidence. If any party feels that I made a gross error in my recollection of the evidence, it would be greatly appreciated if it could be brought to my attention so that the error can be corrected.



David S. Eden, M.D.
Presiding Coroner

April 25, 2014
(date)