

# **POLICE INTERACTIONS WITH PEOPLE IN CRISIS AND USE OF FORCE**

OIPRD Systemic Review Interim Report

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# 1. OVERVIEW



On July 27, 2013, 18-year-old Sammy Yatim was shot and killed by Toronto Police Service (TPS) Constable James Forcillo. Mr. Yatim brandished a switchblade knife on a Toronto Transit Corporation (TTC) streetcar and made a slashing motion towards a female passenger. He also exposed himself to the passengers. The streetcar emptied and passengers called the police. Constable Forcillo was one of the officers who attended the scene. After an interaction with Mr. Yatim lasting about one minute, Constable Forcillo fired three shots. Mr. Yatim was struck and fell to the floor of the streetcar. Once on the floor, he was shot six more times by Constable Forcillo and then struck by a conducted energy weapon (Taser)<sup>1</sup> deployed by another officer. Eight of the nine shots fired by Constable Forcillo struck Mr. Yatim. He died from the injuries.

On August 19, 2013, Constable Forcillo was charged with second degree murder. On July 30, 2014, a charge of attempted murder, in relation to the second volley of shots, was added. After a lengthy trial before a judge and jury, Constable Forcillo was acquitted of murder, but convicted of the attempted murder. On July 28, 2016, he was sentenced to six years in prison. Constable Forcillo has appealed the conviction and sentence and is currently out on bail. The Toronto Police Service has suspended him without pay.

Sammy Yatim's death was a tragedy. An 18 year old young man is dead. His family and friends are devastated by his death. Members of the community have been saddened, deeply troubled and at times, angered by his death. Leaving aside issues of legal responsibility – which have generated a vigorous public debate and of course, a trial – many voices question how and why such an encounter led to death.

Sadly, the Yatim shooting is not an isolated incident. Between 1990 when the Special Investigations Unit was established and December 2016, it is estimated that 142 people were fatally shot in interactions with police in Ontario.<sup>2</sup> Since the Yatim shooting in 2013, 22 men have been

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<sup>1</sup> Taser International is the only conducted energy weapon (CEW) company approved by the Ontario Ministry of Community Safety and Correctional Services for use by police officers in Ontario.

<sup>2</sup> Special Investigations Unit

shot and killed by police in Ontario<sup>3</sup>, including seven in 2016.<sup>4</sup> Also in 2016, Abdirahman Abdi died following a confrontation with Ottawa Police officers in which he was taken to the ground and arrested. The Special Investigations Unit has since charged one Ottawa police constable with manslaughter, aggravated assault and assault with a weapon. Another man, Rui Nabico, went into medical distress and died after a Toronto Police officer discharged a conducted energy weapon at him during an interaction.

In many of these cases, the person shot by the police was “in crisis,” a term adopted by Justice Frank Iacobucci in an important report commissioned by the Toronto Police Service to address its use of lethal force in the wake of the Yatim shooting. Justice Iacobucci defined persons in crisis as members of the public, “whose behaviour brings them into contact with police either because of an apparent need for urgent care within the mental health system, or because they are otherwise experiencing a mental or emotional crisis involving behaviour that is sufficiently erratic, threatening or dangerous that the police are called in order to protect the person or those around them.”<sup>5</sup>

We cannot ignore the fact that, in many of these cases, the deceased was Black or a person of colour.<sup>6</sup> Unfortunately, it is unknown exactly how many civilians killed by the police in Ontario have been Black or of colour as no agency maintains race-based statistics on this issue. The absence of such information has been the focus of criticism for preventing the public from understanding and addressing the full scope of this issue. Regardless, there can be no doubt that overrepresentation of persons of colour who have been killed by the police has aggravated

3 Alex Tughan (2013), Ian Pryce (2013), Michael MacIsaac (2013), Charnjit Singh Bassi (2014), John Caleb Ross (2014), Jermaine Carby (2014), Unnamed male (2014), Daniel Clause (2014), David Doucette (2015), Marc Ekamba-Boekwa (2015), Beau Baker (2015), Unnamed male (2015), Brandon Duncan (2015), Andrew Loku (2015), Kwasi Skene-Peters (2015).

4 Gerald Rattu, Devon LaFleur, Alex Wettlaufer, an unidentified male, Anthony Divers, an unidentified male and Samuel Maloney.

5 Iacobucci, F., *Police Encounters with People in Crisis* (2014), p. 4, para. 2.

6 For example: Lester Donaldson (1988), Michael Wade Lawson (1988), Sophie Cook (1989), Marlon Neal (1990), Ian Clifford Coley (1993), Albert Moses (1994), Tommy Barnett (1996), Andrew Bramwell (1996), Faraz Suleman (1996), Wayne Williams (1996), Hugh Dawson (1997), Edmond Yu (1997), Henry Musaka (1999), Jeffrey Reodica (2004), O'Brien Christopher-Reid (2004), Duane Christian (2006), Junior Alexander Manon (2010), Reyal Jardine Douglas (2010), Eric Osawe (2010), Michael Eligon (2012), Ian Pryce (2013), Sammy Yatim (2013), Jermaine Carby (2014), Marc Ekamba-Boekwa (2015), Kwasi Skene-Peters (2015), Andrew Loku (2015), Abdirahman Abdi (2016) and Rui Nabico (2016).



already existing tensions between racialized communities and the police.<sup>7</sup> This very important issue must be addressed and I intend to do so fully in my final report.

It must be acknowledged that police in Ontario receive an extraordinary number of calls that relate to persons in crisis – approximately 20,000 per year.<sup>8</sup> Typically, these cases end peacefully and without any fatality or injury. We place an enormous responsibility on our police services to respond to and assist persons in crisis. In many instances, they and other first responders demonstrate sensitivity, good judgment and courage in resolving or de-escalating difficult situations. And yet, in too many instances, people in crisis die. As a society, we owe it to all of our members to do everything we can to prevent such tragedies. Even one death is one too many. We must aspire to the goal that no person in crisis dies or is seriously injured as a result of an interaction with the police.

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<sup>7</sup> This is, of course, part of a larger concern involving the shooting of black men by the police. A study conducted in 2006 found that between 2000 and 2006, black men constituted 27 per cent of Ontario deaths from police use of force and 34 per cent of fatal police shootings, despite representing just 3.6 per cent of the population. See Wortley, S. *Police Use of Force in Ontario: An Examination of Data from the Special Investigations Unit* (2006).

<sup>8</sup> Iacobucci, F. *Police Encounters with People in Crisis*, p. 6 para. 11.

# THE OIPRD'S SYSTEMIC REVIEW

## SYSTEMIC REVIEW

As the Independent Police Review Director (Director), I have received numerous public complaints about the use of force by police in dealing with persons in crisis, most particularly in Toronto. Some of those complaints raised important systemic issues. After the Yatim shooting, I concluded that a systemic review of the Toronto Police Service's use of force was required.

Section 57 of the Police Services Act gives the Director the power to examine and review issues of a systemic nature that may give rise to public complaints, and make recommendations to the Minister of Community Safety and Correctional Services, the Attorney General, chiefs of police, police services boards and any other body. A systemic review is not designed to find individual misconduct, but to identify and address larger issues of systemic importance.

On February 24, 2014, I formally announced that I would be conducting a systemic review of the Toronto Police Service's use of force, de-escalation techniques and approach in dealing with people with mental health issues, emotionally disturbed people and people in crisis.

The review was to examine public complaints filed and evidence collected from complaint investigations, recent high-profile use of force incidents involving the TPS, past reviews and reports involving similar issues, including a comprehensive 2014 coroner's inquest that examined some of the issues to be addressed in this review. The review was also to examine TPS policies, procedures and practices regarding use of force and equipment, officer training, best practices from other jurisdictions and relevant research and data. In addition, the review was to consider submissions from stakeholders and the public.



After announcing the systemic review, my office received written submissions from interested parties. We invited every police service across Ontario to provide submissions and then hosted a series of roundtables with mental health experts and community organizations. We also examined the evidence and the jury's recommendations from multiple coroner's inquests that have taken place in Ontario over the last several decades. This included the 2014 inquest into the deaths of Reyal Jardine-Douglas, Sylvia Klibingaitis and Michael Eligon. This inquest engaged in a detailed examination of a number of the issues that figure prominently in our systemic review.

We also reviewed a number of reports on the relationship between the police and the mental health community. Among them was Statistics Canada's *Mental Health and Contact with Police in Canada, 2012* and two reports from the Mental Health Commission of Canada: *TEMPO: Police Interactions – A report towards improving interactions between police and people living with mental health problems* and *Contemporary Policing Guidelines for working with the Mental Health System 2015*.

We carefully examined Justice Iacobucci's report, *Police Encounters with People in Crisis* (Iacobucci Report). On August 28, 2013, former chief William Blair of the TPS requested that Justice Iacobucci undertake an independent review of the use of lethal force by the TPS, with a particular focus on encounters between police and people in crisis. His specific mandate was to conduct an independent review of the policies, practices and procedures of, and the services provided by, the TPS with respect to the use of lethal force or potentially lethal force, in particular in connection with encounters with persons who are or may be emotionally disturbed, mentally disturbed or cognitively impaired.

Justice Iacobucci's report was released in July 2014, several months after our systemic review had commenced. My counsel and I met with Justice Iacobucci to discuss his findings. His mandate and work paralleled, in many respects, the focus of our systemic review. Indeed, his report played an important role in my decision to revise our original Terms of Reference in April 2015. I am delighted and grateful that he has agreed to be a member of my advisory panel for this systemic review.

## The OIPRD's Revised Terms of Reference

Our review of the available reports and literature reinforced my view that much good work had already been done in considering the issues. However, that work left me with as many questions as answers. For example, many coroners' juries over the years had made relevant recommendations for change. To what extent had those recommendations been adopted, rejected or implemented? To what extent would the recommendations made by the coroner's jury at the Jardine-Douglas, Klibingaitis, Eligon inquest or those made by Justice Iacobucci be adopted, rejected or implemented? How do practices around use of force in dealing with persons in crisis differ between police services in Ontario, and what can we say about best practices across the province?

In my view, it was important not to simply replicate the work done by others and waste valuable resources in doing so, but instead re-focus our systemic review. Before doing so, I consulted with several police and community stakeholders. Their input was invaluable in crafting revised Terms of Reference.

On April 20, 2015, when I announced the revised Terms of Reference for the systemic review, I said:

**“** *While the original review focused on the Toronto Police Service, in order to ensure my recommendations have relevance more broadly to policing across the province, I have revised and expanded the Terms of Reference to extend to police services throughout Ontario. The review will focus more intently on the extent to which recommendations made in the past have been implemented. It will also examine the relationship between Ontario Police College training and training by police services; the content and use of “use of force reports”; and the interplay between government, mental health agencies and police services in addressing the needs of persons in distress, while protecting the public.* **”**

I also said that during the course of the review, I may release interim reports, with a final report summarizing the findings of the review and outlining recommendations and advice for the overall improvement of police practices to be released publicly.

# THIS INTERIM REPORT

## INTERIM REPORT

As reflected in the April 20, 2015, announcement, I have decided to issue an interim report at this time. Its primary purpose is to document, in some detail, the many relevant recommendations that have been made by Ontario coroner's inquests in the past, including the Jardine-Douglas, Klibingaitis, Eligon inquest, as well as the recommendations made by Justice Iacobucci. The recommendations are grouped by subject matter, which will better enable me to examine what the police services in Ontario have done to address or implement these recommendations and identify best practices in Ontario in responding to people in crisis.

This interim report is intended to stimulate an informed discussion with stakeholders and members of the public about the issues and provide a blueprint for the work that we will do in the upcoming months.

# 2. WORK DONE TO DATE



# THE OIPRD'S REVIEW OF CORONER'S INQUESTS

## INQUESTS

The OIPRD has examined the recommendations made at 32 coroner's inquests from 1996 to 2016. As reflected earlier, one of these was a combined inquest into the death of three people: Reyal Jardine-Douglas, Sylvia Klibingaitis and Michael Eligon. Several of the inquests had fairly limited recommendations, unique to the circumstances of the relevant death. However, many of the inquests examined the larger systemic issues carefully and the recommendations resonate with those made in other inquests. Some important, basic themes emerge from our review. These are significant not only because the inquests heard evidence on these points, but also because the recommendations were formulated by randomly selected members of the community.

We examined the coroner's inquests into the deaths of the following individuals:

Name of Deceased	Year Inquest Recommendations Issued	Involved Police Service
Winston Grosvenor	1996	Toronto
Scott Andrew Ambeault	1996	OPP
Zdrovko Puhec	1996	Durham Regional
Edmond Wai-Kong Yu	1999	Toronto
David Neil Schlaht	1999	Kingston
Wayne Rick Williams	2000	Toronto
Kerri Nicole Cuddy	2004	Peel Regional

<b>Name of Deceased</b>	<b>Year Inquest Recommendations Issued</b>	<b>Involved Police Service</b>
Nicholas Blentzas	2005	Toronto
Peter Lamonday	2005	London
Otto Vass	2006	Toronto
O'Brien Christopher-Reid	2007	Toronto
Jason Earl Steacy	2008	OPP
Jerry Knight	2008	Peel Regional
Michael Douglas	2008	Sarnia
Trevor Colin Graham	2009	Waterloo Regional
James Foldi	2009	Niagara Regional
Harold James Maltar	2009	OPP
Byron Richard DeBassige	2010	Toronto
Levi Schaeffer	2011	OPP
Gino Petralia	2011	Durham Regional
Sean Reilly	2011	Peel Regional
Evan Thomas Jones	2012	Brantford
Aron James Firman	2013	OPP
Reyal Jardine-Douglas, Sylvia Klibingaitis and Michael Eligon	2014	Toronto
Charles McGillivray	2014	Toronto
Matthew Roke	2014	OPP
Douglas Clive Minty	2014	OPP
Andreas Unkerskov-Chinnery	2016	Hamilton
Ian Glendon Pryce	2016	Toronto
Jermaine Anthony Carby	2016	Peel Regional
Daniel Nickolas Clause	2016	Toronto
David Andrew Doucette	2016	Toronto

Additional inquests have been announced by the coroner's office.

On April 13, 2016, a coroner's inquest was announced into the death of Andrew Loku, who died on July 5, 2015, of injuries sustained when he was shot by a member of the Toronto Police Service. The circumstances surrounding Mr. Loku's death and the fact that he was a Black man have generated a high degree of public scrutiny, discussion, concern and anger. The inquest has been scheduled to commence on June 5, 2017.

On August 10, 2016, a coroner's inquest was announced into the death of Beau Baker, who died of injuries sustained when he was shot by a Waterloo Regional Police Service officer on April 2, 2015. The inquest has not yet been scheduled.

On November 30, 2016, a coroner's inquest was announced into the death of Michael MacIsaac, who died on December 3, 2013, following an interaction with the Durham Regional Police, during which Mr. MacIsaac was shot. The inquest has been scheduled for July 17, 2017.

Following is the list of the individuals whose deaths were reviewed at a coroner's inquest, the recommendations of which have been examined by this office. The list contains some additional basic information, including their name, gender, age, race (if known) and date of death. It also lists the cause of death (if known) and the verdict reached by coroner at the end of the relevant inquest. This provides some basic factual background about the individuals who died and what caused their death.

This report will not, however, delve into the background of these individuals or the events leading to their deaths. That is because the focus of our work is more narrow: namely to identify and organize the list of recommendations made to date with respect to these cases and ultimately, to provide the groundwork for a review of the implementation of those recommendations. Given that focus, this report cannot fully and properly detail the background of each of these individuals or the circumstances of their deaths.

This is not meant as a sign of disrespect to the individuals who died or their loved ones. These individuals were clearly much more than a name, an age, a gender, a race and a date of death. They were all people, sons or daughters (and often brothers, sisters and/or parents) imbued with all the dignity and complexity that comes with the human experience. I do

not wish to minimize that in any way. In fact, I would be concerned that any effort to do so could never do justice to these individuals' humanity or the tragic circumstances of their death.

I am comforted by the knowledge that in each case there was an extensive coroner's inquest that heard evidence about exactly these issues, ultimately rendered a verdict and proposed recommendations. I hope that the inquest process, which has a very different focus from this report, ensured that the humanity and dignity of all those who died was fully examined and captured. I also hope that the inquest process ensured that anyone who was involved in one of these cases had the opportunity to express their particular perspective.

For those who may seek a greater understanding of any individual case, that information is captured in the verdict of the respective inquest and can be accessed on the CanLII database: <http://www.canlii.org/en/on/onocco/index.html>. In addition, the coroner's verdicts from 2014 to the present are accessible on the coroner's website: [http://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/Inquests/VerdictsRecommendations/OCC\\_verdicts\\_alpha.html](http://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/Inquests/VerdictsRecommendations/OCC_verdicts_alpha.html).

Name	Gender	Age	Race	Date of Death	Cause of Death	Verdict
Winston Grosvenor <sup>9</sup>	Male	32	U/K <sup>10</sup>	Feb 2, 1992	Cardio vascular collapse precipitated by cocaine poisoning and positional asphyxia; excited delirium precipitated by cocaine intoxication, made worse by positional asphyxia	Accidental overdose
Scott Andrew Ambeault	Male	35	U/K	Jun 29, 1995	Cardiorespiratory arrest due to moderate coronary artery disease, fractured rib, hog-tie position, exhaustion and the effects of excited delirium	Accident

<sup>9</sup> Inquest verdicts are not available for Winston Grosvenor, Scott Ambeault and Zdrovko Pukey.

<sup>10</sup> U/K indicates unknown.



Name	Gender	Age	Race	Date of Death	Cause of Death	Verdict
Zdrovko Pukec	Male	26	White	Sep 26, 1995	Cardio pulmonary arrest associated with acute psychosis, physical restraint positional asphyxia, exhaustion and stress due to pepper spray	Accident
<u>Edmond Wai-Kong Yu</u>	Male	35	Chinese	Feb 20, 1997	Gunshot wounds to the head and neck	Homicide <sup>11</sup>
<u>David Neil Schlaht</u>	Male	35	U/K	May 22, 1998	Excited delirium associated with restraint	Accident
<u>Wayne Rick Williams</u>	Male	24	Black	Jun 11, 1996	Multiple gunshot wounds	Homicide
<u>Kerri Nicole Cuddy</u>	Female	21	U/K	Jun 16, 2003	Stab wound to chest	Suicide
<u>Nicholas Blentzas</u>	Male	24	U/K	Jun 23, 2002	Excited delirium/restraint asphyxia associated with an underlying psychiatric illness	Accident
<u>Peter Lamonday</u>	Male	33	U/K	May 14, 2004	Cocaine induced excited delirium	Accident
<u>Otto Vass</u>	Male	55	White	Aug 9, 2000	Sudden unexpected cardiac death due to: acute mania, excited delirium in a man with a longstanding bi-polar disorder; in association with cardiovascular stress resulting from violent struggle and morbid obesity	Undetermined

<sup>11</sup> The Coroner's Office defines homicide as a death that results from the action of a human being killing another human being. It does **not** mean that the action that led to the death is a criminal act. (i.e., culpable homicide as defined by the Criminal Code of Canada).

Name	Gender	Age	Race	Date of Death	Cause of Death	Verdict
<u>O'Brien Christopher-Reid</u>	Male	26	Black	Jun 13, 2004	Multiple gunshot wounds of posterior torso and left lateral chest, perforating left lung	Homicide
<u>Jason Earl Steacy</u>	Male	20	U/K	Nov 5, 2005	Gunshot wound to the chest with exsanguination and lung collapse	Homicide
<u>Jerry Knight</u>	Male	29	U/K	Jul 17, 2004	Restraint asphyxia following prolonged struggle, due to cocaine-induced excited delirium	Homicide
<u>Michael Douglas</u>	Male	35	U/K	Mar 7, 2007	Gunshot wound to chest	Homicide
<u>Trevor Colin Graham</u>	Male	26	White	Nov 20, 2007	Single gunshot wound to the chest	Homicide
<u>James Foldi</u>	Male	39	U/K	Jul 1, 2005	Acute cocaine toxicity leading to sudden cardiac death, in the setting of excited delirium	Accident
<u>Harold James Maltar</u>	Male	45	U/K	Sep 18, 2005	Gunshot wound to the head, perforating the brain	Suicide
<u>Byron Richard DeBassige</u>	Male	28	First Nations	Feb 16, 2008	Gunshot wounds to the torso	Homicide
<u>Levi Schaeffer</u>	Male	30	White	Jun 24, 2009	Gunshot wound to torso	Homicide
<u>Gino Petralia</u>	Male	47	U/K	Nov 29, 2008	Perforating gunshot wound of torso	Homicide

Name	Gender	Age	Race	Date of Death	Cause of Death	Verdict
<u>Sean Reilly</u>	Male	42	U/K	Sep 17, 2008	Acute cocaine intoxication with excited delirium	Accident
<u>Evan Thomas Jones</u>	Male	18	White	Aug 25, 2010	Gunshot wound	Homicide
<u>Aron James Firman</u>	Male	27	White	Jun 24, 2010	Cardiac arrhythmia due to excited delirium and schizophrenia; contributing factors of cardiomegaly, CEW deployment, and SCN5A polymorphism	Accident
<u>Reyal Jardine-Douglas</u>	Male	25	Black	Aug 29, 2010	Penetrating gunshot wound to the left shoulder	Homicide
<u>Sylvia Klibingatis</u>	Female	52	White	Oct 7, 2011	Perforating gunshot wound of chest	Homicide
<u>Michael Eligon</u>	Male	29	Black	Feb 3, 2012	Penetrating gunshot wound to right side of neck	Homicide
<u>Charles McGillivary</u>	Male	45	White	Aug 1, 2011	Cardiac arrhythmia precipitated by struggle and restraint in the context of multiple medical conditions, including catecholaminergic polymorphic ventricular tachycardia	Accident
<u>Matthew Roke</u>	Male	33	White	May 2, 2012	Perforating gunshot wounds to the right side of chest	Homicide
<u>Douglas Clive Minty</u>	Male	59	White	Jun 22, 2009	Multiple gunshot wounds	Homicide

Name	Gender	Age	Race	Date of Death	Cause of Death	Verdict
<u>Andreas Unkerskov-Chinnery</u>	Male	19	White	Feb 2, 2011	Perforating gunshot wound of abdomen	Homicide
<u>Ian Glendon Pryce</u>	Male	30	Black	Nov 13, 2013	Gunshot wounds to the back	Homicide
<u>Jermaine Anthony Carby</u>	Male	33	Black	Sep 24, 2014	Gunshot wounds to torso	Homicide
<u>Daniel Nickolas Clause</u>	Male	33	White	Dec 31, 2014	Multiple gunshot wounds	Homicide
<u>David Andrew Doucette</u>	Male	49	U/K	Feb 18, 2015	Gunshot wound to neck	Homicide

# THE RECOMMENDATIONS FROM THE INQUESTS

## RECOMMENDATIONS

As reflected earlier, all of these deaths resulted in coroner's inquests. And in almost every case, the coroner's jury made recommendations in an effort to prevent these tragedies from re-occurring. We have organized those recommendations, reproduced verbatim, into the following categories:

1. The Mental Health System in Ontario
2. Public Education about the Mental Health System
3. Coordination and Communication Between the Mental Health System and Police
4. The Sharing of Individualized Information
5. Police Culture
6. Recruitment and Hiring of Police Officers
7. Police Training
8. Conducted Energy Weapons (Tasers)
9. Pepper Spray and Other Equipment
10. Body Worn Cameras and In-car Cameras
11. The Use of Force Model
12. Police Supervision
13. Mobile Crisis Intervention Teams (MCITs)
14. Implementation of Recommendations and Funding



## 1. THE MENTAL HEALTH SYSTEM IN ONTARIO

One cannot fully understand or address the issue of police use of force when dealing with people in crisis without also considering the broader societal issues that contribute to these encounters. The reality is that we are only now as a society beginning to recognize the breadth and scope of mental health issues in Ontario (and across Canada). A more open discussion about mental health has begun to take place, thanks in part to some decrease in the stigmatization of those who live with mental health issues. Yet much work remains to be done in this area.

Sadly, our growing understanding of the scope of mental illness has been accompanied by a recognition that the resources we currently have in place are woefully inadequate. Many people who are living with mental health issues are not being effectively treated. This is certainly not a critique of the many dedicated and hard-working people who work in the field of mental health. Rather, it is a reflection that there is often insufficient support for them and their work. The end result is that in many instances, the police have become the primary responders for persons in crisis. As stated eloquently by one of the participants at our expert roundtable on mental health:

**“** *If you don't want the police to be the default mental health system, you need to build a proper, functioning mental health system.* **”**

In a similar vein, Justice Iacobucci wrote:

**“** *There is a huge issue that warrants further elaboration: the mental health system. One cannot properly deal with the subject of police encounters with people in crisis and not consider the availability of access to mental health and other services that can play a role in the tragic outcomes for people in crisis in*

*encounters with the police. Police officers, because of their 24/7 availability and experience in dealing with human conflict and disturbances, are inexorably drawn into mental and emotional fields involving individuals with personal crisis.*

*As I emphasize in the Report, there will not be great improvements in police encounters with people in crisis without the participation of agencies and institutions of municipal, provincial and federal governments because, simply put, they are part of the problem and need to be involved in the solution.*

*In many ways, I have found this reality the most distressing societal aspect of my work on the Review. The effective functioning of the mental health system is essential as a means of preventing people from finding themselves in crisis in the first place. There is not much I can do through my recommendations to remedy the applicable problems in the mental health system, since I can recommend changes only to the TPS. But the basic and glaring fact is that the TPS alone cannot provide a complete answer to lethal outcomes involving people in crisis.<sup>12</sup> ”*

Many of the recommendations made by coroner’s juries have focused on the need for improvements to the mental health system. Broadly speaking, the recommendations have identified the need for additional resources and training to improve the availability and quality of care provided to Ontarians. These recommendations, along with the recommendation number are set out below.

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## **ZDROVKO PUKEC INQUEST RECOMMENDATIONS (1996)**

3. That the Ministry of Health provide funding to review mechanical restraints presently in use in psychiatric facilities for the purpose of

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<sup>12</sup> *Police Encounters with People in Crisis*, An Independent Review Conducted by the Honourable Frank Iacobucci for Chief of Police William Blair, Toronto Police Service, July 2014, para 39, 40 and 41.

replacing them with restraints providing the same function but more user friendly.

4. That Whitby Psychiatric Hospital obtain a defibrillator for its facility.
5. That the duty doctor at Whitby Psychiatric Hospital be trained and certified in Advanced Cardiac Life Support.
6. That Whitby Psychiatric Hospital ensure that all “quiet rooms” used for secluding patients potentially harmful to themselves or others and all intensive observation and treatment units be equipped with non-breakable glass.
9. That the Whitby Psychiatric Hospital establish and maintain a list of second languages spoke [sic] by staff to assist with patient communication.

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### **EDMOND WAI-KONG YU INQUEST RECOMMENDATIONS (1999)**

4. The Ministry of Health should include a member of the mental health community in the drafting of amendments to mental health legislation in order to facilitate its comprehension by members of that community.
5. Ensure that all psychiatrists and psychiatric residents receive training and/or further education on the Mental Health Law of Ontario.
6. That all psychiatrists and psychiatric residents be educated that there are ethno-specific issues in psychiatry.
9. The Ministry of Health should create a long-term case management system whereby caseworkers will follow consumers of mental health services on a long-term or permanent basis.



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### **WAYNE RICK WILLIAMS INQUEST RECOMMENDATIONS (2000)**

1. The Ministry of Health and Long-Term Care should ensure that a range of mental health crisis services be available throughout the Greater Toronto Area and that the information regarding these services be readily available to the public.
2. The Ministry of Health and Long-Term Care require hospitals to develop protocols to ensure that:
  - a) Their staff, including doctors, are aware of all available mental health services such as case managers, assertive community treatment teams, mobile crisis units, crisis centres and the hospitals which have 24 hour enhanced mental health emergency crisis hospital services
  - b) Their staff, including doctors, fully inform patients and families of patients of these available services
  - c) All mentally ill patients are given the option to be linked up with case managers
  - d) Discharge instructions should be signed by the patient or caregiver and the person who gave the instructions
  - e) If an individual discharges himself or herself against medical advice, that the person or care giver, is offered all information respecting available resources and offered assistance in accessing them.

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### **KERRI NICOLE CUDDY INQUEST RECOMMENDATIONS (2004)**

1. That it be taken under consideration that as part of the discharge process for patients determined to be in need of continuing care, that it be clearly noted in writing on the discharge papers the identity of the attending outpatient psychiatrist. The purpose being to make it clear to the members of the continuing care agencies who the

psychiatric physician is. In the event that the patient does not have one, to designate a psychiatrist to the patient in order to ensure a continuum of care.

2. We also recommend that the communication process between the front line workers of community care agencies, such as visiting nurses and or social workers, and the patient's psychiatrist and family physician be reviewed with a view to increase the flow of information between these parties especially in the period immediately after discharge. In particular, we the jury, recommend that a copy of any notes taken by the visiting nurse and or social worker be forwarded to the attending psychiatrist and family physician on a per visit basis.

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### **OTTO VASS INQUEST RECOMMENDATIONS (2006)**

12. In order to minimize police encounters with individuals in crisis, the MOHLTC, LHINs, and all mental health services should consider enhancing funding to overtaxed alternatives to hospitalization and criminalization, e.g., nonmedical crisis services (such as the Gerstein Centre) and pre-charge diversion options.
13. The MOHLTC, LHINs, and all mental health services should meet the self-identified needs of the psychiatric consumer/survivor community, by ensuring appropriate consultation with an advisory group of psychiatric consumers and survivors.
14. The MOHLTC, LHINs, and all mental health services should ensure that there is dialogue between the emergency departments of hospitals and mental health service providers, such as the Gerstein Centre and the Centre for Addiction and Mental Health (CAMH), to ensure that psychiatric consumers/survivors triaged in emergency departments, who cannot be admitted, are made aware of all the alternative mental health support services available to them.

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### **O'BRIEN CHRISTOPHER-REID INQUEST RECOMMENDATIONS (2007)**

12. That the Ministry of Health and Long Term Care review and consider current legislation policies and funding to address:
  - a) Criteria by which patients are released from psychiatric hospitals
  - b) Community and nursing support for released patients
  - c) Family support mechanisms that include:
    - i. Education and counseling of patient's specific disorders
    - ii. Further considerations for doctors to use discretion to disclose to a patient's family and significant others any pertinent information.

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### **MICHAEL DOUGLAS INQUEST RECOMMENDATIONS (2008)**

1. All health care facilities with self-contained psychiatric facilities should consider the placement of surveillance and video equipment which incorporates audio and visual alarm such that "blind spots" and fire escape routes can be adequately observed. As well the use of key operated pull stations for activation of fire alarms should be considered.

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### **BYRON RICHARD DEBASSIGE INQUEST RECOMMENDATIONS (2010)**

1. The Ministry of Health and Long Term Care should create a single organization to be a comprehensive coordinating body in Ontario for mental health and addiction services.
2. The Ministry of Health and Long Term Care should review the current portfolio of mental health and addiction services to assess if there is an appropriate balance of services with respect to needs and to adjust if so indicated.

3. The Ministry of Health and Long Term Care, along with mental health law experts, police and others in the field of mental health, should review the mental health legislation regarding involuntary admission and treatment, to better address the needs of those who do not or cannot avail themselves of services and treatment because of their illness.
4. The Ministry of Health and Long Term Care should make funds available for the creation of additional teams, which provide comprehensive community-based psychiatric treatment and support, commonly referred to as Assertive Community Treatment (ACT) teams, to serve mentally disordered persons in the community.
5. The Ministry of Health and Long Term Care should revisit the Mental Health Act to consider whether the legislative criteria for a Community Treatment Order are too restrictive, with the specific recommendation that it should be adjusted to encompass those who have been inmates in correctional psychiatric facilities.
6. The Ministry of Health and Long Term Care should launch a study to assess the need for supportive housing facilities (voluntary and involuntarily) for persons who suffer from mental illness/disability and/or addiction and, if indicated, to establish such a facility or facilities to include programs that will meet the needs of the intended resident including Aboriginal Peoples.

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### **GINO PETRALIA INQUEST RECOMMENDATIONS (2011)**

2. Recommend a review to consider amending the existing law to allow alternate mechanisms to force or trigger a Community Treatment Order in instances where there is chronic mental health and/or a violent history. (E.g., Courts, or Probation Officers, or Mental Health Services to initiate a Community Treatment Order without necessarily having the consent of the client in the cases where there is a chronic mental health and/or violent history and repeated refusals of treatment.)

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## **EVAN THOMAS JONES INQUEST RECOMMENDATIONS (2012)**

17. To ensure continuity of care and the coordination of services for persons with mental illness, assess the feasibility of a case management system for persons involved with two or more service providers within/funded by the Ministry of Community Safety and Correctional Services and/or Ministry of Health and Long-Term Care, where:
  - a) Case managers have manageable workloads
  - b) Case managers would have access to criminal records, medical data, data related to counseling and other community services
  - c) Information would flow between these services and the case manager, but not necessarily between services
  - d) Consent would be provided by the client to the case manager to have access to the data from these services
  - e) Funding for this could be offset by reduced cost of duplications and demands on other services (e.g., emergency room and hospital visits, police services, etc.)
  - f) Case managers would ensure and monitor that bail and probation conditions were being met.
  
20. To reduce wait times for addiction services across Ontario:
  - a) Increase the capacity of community based mental health and addiction services based on demonstrated community need
  - b) Establish a provincial maximum wait time for access to defined services (withdrawal services, psychiatric services and counseling services, etc.)
  - c) Provide adequate funding to meet the standards addressed in (b)
  - d) Implement a residential treatment program and withdrawal program in Brantford.
  
21. To improve safety of the public and the patient and to reduce or eliminate patient elopements, increase security in all mental health wards caring for involuntary mental health admissions.

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## **JARDINE-DOUGLAS, KLIBINGAITIS, ELIGON INQUEST RECOMMENDATIONS (2014)**

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

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### **MATTHEW ROKE INQUEST RECOMMENDATIONS (2014)**

7. [MCSCS, OPP, OACP and MOHLTC] should produce an interpretation bulletin in order to clarify the criteria for apprehension under Section 17 of the Mental Health Act (MHA). This interpretation should include reference to the importance of information provided by the family and/or caregivers of the individual being assessed.



Consideration should be given to the production of an assessment tool for the use of police officers.

8. The MOHLTC should increase the availability and funding of hospital based addiction treatment services in Schedule 1 psychiatric facilities and explore the possibility of introducing a harm reduction model of treatment for dual diagnosis patients with the sole intent of engaging the patient to facilitate treatment for the mental illness while in a Schedule 1 psychiatric facility.
9. The MOHLTC should produce an interpretation bulletin for mental health care providers in order to clarify the concept of “circle of care” and the consent required to permit sharing within that circle, with consideration given to including the family in this circle where appropriate.
10. The MOHLTC should review the Mental Health Act as it pertains to the capacity and consent criteria with the intent of facilitating apprehension, assessments, access to treatment and other services for patients with a chronic mental illness.
11. The MOHLTC should review the Mental Health Act as it pertains to sharing of information within the circle of care, with the intent of facilitating communication between parties within the circle of care.
12. The MOHLTC should produce an interpretation bulletin for mental health care providers in order to clarify the process of determining capacity.
13. The MOHLTC should study the need for long term in-patient services for patients with severe, chronic mental illness.



## **2. PUBLIC EDUCATION ABOUT THE MENTAL HEALTH SYSTEM**

Another theme that emerges from these inquests is the lack of public knowledge about the mental health system, the laws that govern that system and the resources that are available to help those with mental health issues or in crisis. Accordingly, a number of the coroner's juries have made recommendations to improve public education about the services that are available.

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### **WAYNE RICK WILLIAMS INQUEST RECOMMENDATIONS (2000)**

3. The Ministry of Health and Long-Term Care should continue to support various initiatives to educate consumer/survivors, affected family members, the police, and health care providers about relevant mental health law and the roles and responsibilities of the various players in the mental health system.

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### **O'BRIEN CHRISTOPHER-REID INQUEST RECOMMENDATIONS (2007)**

11. That the Ministry of Health and Long Term Care consider promoting and advertising to the general public, information about the Mental Health and Justice Services Community Referral Access Line and the related telephone numbers.

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### **EVAN THOMAS JONES INQUEST RECOMMENDATIONS (2012)**

11. To ensure timely and accurate information regarding the availability of local services for persons with mental health issues, require all police officers to provide persons with mental illness whom they encounter in the course of duty, and their families, if available, with information in an accessible format (i.e., business card, fridge magnet, etc.) regarding the ConnexOntario program and local mental health service providers.
19. To ensure timely and accurate information regarding the availability of local services for persons with mental health issues, promote and raise public awareness about ConnexOntario.

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### **JARDINE-DOUGLAS, KLIBINGAITIS, ELIGON INQUEST RECOMMENDATIONS (2014)**

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.
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.
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.

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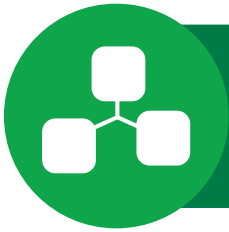
## **MATTHEW ROKE INQUEST RECOMMENDATIONS (2014)**

17. The MOHLTC should fund at least one position within each LHIN, the duties of which would include providing information with respect to the types of addictions and mental health services available in the community, and the requirements for accessing such services, if any. The contact information for the person(s) in this position should be made as simple and as easy to locate as possible, so that persons in need of addictions and/or mental health services, their family members, or care providers, need only make one contact in order to be connected with the appropriate information and services.
18. The MOHLTC should fund and produce a public service announcement appealing to people to seek treatment for themselves or a loved one.

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## **ANDREAS UNKERSKOV-CHINNERY INQUEST RECOMMENDATIONS (2016)**

5. Consider developing and/or enhancing public awareness campaigns to educate the public, and particularly youth, about recognizing the early signs and symptoms of mental illness. Consider engaging young people in the development of this campaign that speaks directly to this audience. Campaign information should include resources available within the community that provide support and potential intervention to the persons needing them.
15. Explore ways to educate young people about the Crisis Outreach and Support Team (COAST) program and how to access the services of COAST.



### **3. COORDINATION AND COMMUNICATION BETWEEN THE MENTAL HEALTH SYSTEM AND POLICE**

A common thread throughout these inquests has been the lack of coordination and communication between the mental health system and the police. Multiple coroner's juries have recommended that there be more formalized and structured relationships between the two systems to allow all parties to be more informed about and better equipped to assist people suffering from mental health issues or in crisis.

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#### **ZDROVKO PUKEC INQUEST RECOMMENDATIONS (1996)**

1. That the Durham Regional Police Service and the Whitby Psychiatric Hospital (Whitby Mental Health Care Centre) conduct annual meetings for the purpose of reviewing requests for police assistance at the hospital. This review should include but not be limited to:
  - a) The number of calls
  - b) The circumstances requiring police assistance
  - c) The nature of the assistance rendered
  - d) An appraisal of the results of the assistance.

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#### **EDMOND WAI-KONG YU INQUEST RECOMMENDATIONS (1999)**

21. That representatives of consumer survivor groups, in consultation with the Community Policing Support Unit should develop a pamphlet for police to give to persons in crisis on how to access services. The pamphlet should be prepared in several different languages to serve our diverse community.

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### **PETER LAMONDAY INQUEST RECOMMENDATIONS (2005)**

15. The Ministry of Health and Long Term Care and the Ministry of Community Safety and Correctional Services should develop a protocol for ensuring effective and relevant communication between the hospital and the police when an in-custody patient is being transported to the hospital. This communication should provide as much information as possible regarding the incoming patient for the hospital emergency staff.
16. London Health Sciences Centre should develop a check list of questions for the police dispatch operator and the emergency room operator to use in order to provide as much information as possible regarding the incoming patient for the hospital emergency staff. This check list can include information such as what intervention has taken place (e.g., pepper spray, Tasers), activities of patient (e.g., hallucinating, violent) and physical condition of patient. This list should be passed to the triage nurse.

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### **OTTO VASS INQUEST RECOMMENDATIONS (2006)**

11. The Toronto Police Service should establish an enduring structure for dialogue to address the intersection of policing and issues that arise in the mental health sector. The recommendations developed during these meetings should be given consideration in the context of decision making, including policy-making, setting police priorities and budget considerations. This group would involve representation from senior levels of the Toronto Police Service, representatives of the consumer/survivor community and service providers in the mental health field. This group would address issues of concern and facilitate the services provided to the psychiatric consumer/survivor community. The group would address issues such as:

- Reviewing analysis and research conducted in the area of policing and mental health
- Making recommendations regarding policing/mental health issues in order to achieve the best outcomes for psychiatric survivors
- Ensuring significant psychiatric consumer/survivor community input and active participation in police initiatives, steering committees and police training in the area of mental health
- On-going examination and review of alternatives to situations leading to the use of force, particularly lethal force (e.g., mobile crisis teams, Tasers)
- Education of the public to avoid the stereotyping and demonization of psychiatric consumers/survivors and the police in the media
- Education of the psychiatric consumer/survivor community to explain what this community expects the police to do, and what the police require to carry out these duties
- Ensure that all parties are aware of the services provided by the various mental health service providers.

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### **MICHAEL DOUGLAS INQUEST RECOMMENDATIONS (2008)**

4. Hospitals, police services and community mental health agencies should jointly develop a crisis management plan regarding training, communications, expectations and services provided by and for each other.

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### **JAMES FOLDI INQUEST RECOMMENDATIONS (2009)**

6. It is recommended that the Niagara Regional Police Services and Niagara Emergency Medical Services continue to work together in developing communications protocols that are aimed at the prompt attendance of ambulance services at the scene of medical situations that also require a police response.

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### **LEVI SCHAEFFER INQUEST RECOMMENDATIONS (2011)**

6. The Ministry of Community Safety and Correctional Services should consult with relevant professionals to assess the need for officers to receive further ongoing training on the recognition of and intervention with individuals who are emotionally disturbed/mentally ill.
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### **SEAN REILLY INQUEST RECOMMENDATIONS (2011)**

12. To encourage the development of a multidisciplinary roundtable through which directives with respect to recognition and treatment of excited delirium can be developed.
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### **EVAN THOMAS JONES INQUEST RECOMMENDATIONS (2012)**

9. To ensure that the appropriate resources and level of response required are known in advance of police attendance, enhance and continue to ensure that all communications and dispatch personnel receive mandatory up-to-date training with respect to:
  - a) Making all necessary inquiries during the initial call to police to determine if mental illness may be factor
  - b) Making the necessary checks of the SIP portion of CPIC; NICHE; and Cad to determine if there are any flags relating to suicide risk, mental health issues or special situations.
10. To ensure that the appropriate flags in relation to suicide risk, mental health issues, or special situations must be entered into the SIP portion of CPIC; NICHE; and CAD, enhance and continue to ensure that all sworn police officers receive mandatory up-to-date training with respect to:



- a) The categories for flagging
  - b) The procedure and importance of flagging on the SIP portion of CPIC
  - c) The procedure and importance of flagging on NICHE
  - d) The procedure and importance of entering information relating to Special Situations associated with certain addresses
  - e) The development of a simplified process (i.e. a common form) for the request of the addition of flags to NICHE, CAD and the SIP portion of CPIC.
14. To ensure that persons with identified suicide risk or mental health issues are flagged on the SIP portion of CPIC in a timely manner, investigate the feasibility of a simplified application process.

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### **ARON JAMES FIRMAN INQUEST RECOMMENDATIONS (2013)**

16. Encourage liaison between OPP Detachments and local area mental health professionals to inform and educate both police and mental health workers about available resources in their area, including mental health facilities and homes/hostels housing clients with mental health issues, to ensure that optimum mental health services are provided to meet the needs of those clients.

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### **JARDINE-DOUGLAS, KLIBINGAITIS, ELIGON INQUEST RECOMMENDATIONS (2014)**

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.

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.
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.
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.

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## **IACOBUCCI REPORT (2014)**

1. The TPS create a comprehensive police and mental health oversight body in the form of a standing inter-disciplinary committee that includes membership from the TPS, the 16 designated psychiatric facilities, the three Local Health Integration Networks covering Toronto, Emergency medical Services, and community mental health organizations to address relevant coordination issues including:
  - c) Mutual Training and Education: how psychiatric facilities, community mental health organizations and the TPS can benefit from mutual training and education
  - d) Informing Policymakers: informing policymakers at all levels of government, in the aim of making the mental health system more comprehensive
  - e) Advocacy: advocating more comprehensive and better-funded community supports for people with mental illness. This would be a multi-party initiative led by the mental health sector. It should

include, among other things, planning for community treatment supports upon discharge from the hospital, and the creation of more “safe beds” in shelters for people in crisis, to be used when they do not meet the criteria for apprehension under the Mental Health Act but need assistance to stabilize their crisis

- f) Reducing Emergency Department Wait Times: a standardized approach to reducing emergency department wait times for police officers bringing in a person in crisis and transferring care to the hospital. Some relevant measures to be considered include:
  - i. Developing a standard transfer of care protocol that minimizes emergency department wait times, and across Toronto’s 16 psychiatric emergency departments. This protocol may build on existing efforts underway
  - ii. Providing cross-sectoral training for officers and emergency department staff about apprehensions under the Mental Health Act and transfer of care
  - iii. Ensuring adequate communication between officers and emergency departments when en route with a person in crisis to allow the emergency department to make necessary preparations
  - iv. Arranging a separate waiting area for police-accompanied visitors to the emergency department
  - v. Having adequate staff to manage mental health crisis situations in the emergency department
  - vi. Designating a liaison in the emergency department to work with police officers when they arrive with a person in crisis
  - vii. Developing a protocol between police services and hospitals that sets out specific procedures, expectations, and respect for patient rights
  - viii. Conducting routine monitoring and evaluation of the protocols put in place, and making any changes warranted
  - ix. Developing a protocol for how psychiatric facilities’ emergency department capacities can be effectively communicated to officers in a timely manner

- x. Developing a protocol to address how people apprehended under the Mental Health Act can be equitably distributed among Toronto's 16 psychiatric facilities to ensure the best medical treatment and shortest emergency department wait times
  - g) Other Matters: any other matters of joint interest.
- 2. The TPS more proactively and comprehensively educate officers on available mental health resources, through means that include:
  - a) Mental Health Speakers: inviting members of all types of mental health organizations to speak to officers at the divisions
  - b) Technological Access to Mental Healthcare Resources: considering the use of technological means, similar to Vancouver's "Dashboard" system, to efficiently communicate to officers a comprehensive up to-date list or map of available mental health resources of all types in their area. Such an easily accessible reference tool should aggregate information on all community supports, in addition to major psychiatric facilities
  - c) Point of Contact: working with mental health organizations to identify key resource people or liaisons, so that every TPS officer has a contact in the mental health system that they feel comfortable contacting for advice and who is able to knowledgeably give that advice.
- 3. The TPS amend Procedure 06-04 "Emotionally Disturbed Persons" to provide for the mandatory notification of MCIT units for every call involving a person in crisis.
- 4. The TPS, either through the Mental Health Subcommittee of the Toronto Police Services Board or another body created for this purpose, consider ways to bridge the divide between police officers and people living with mental health issues. This initiative, in furtherance of the formal commitments recommended in Recommendation 5, and building on the mandate for community-oriented policing placed on all police services in Ontario under section 1 of the Police Services Act, may include:

- a) Divisional Meetings: inviting members of the community of people who have experienced mental health issues into divisional meetings to speak with officers
  - b) Community Gathering Places: officers building collaborative relationships with people who have experienced mental health issues at drop-ins, clubhouses, and other gathering places
  - c) Leadership: the TPS Mental Health Coordinator and Divisional Mental Health Liaison Officers facilitating the initiatives in subsections (a) and (b), as well as other relationship-building and de-stigmatizing programs.
83. The TPS collaborate with academic researchers, hospitals and others to evaluate the effectiveness of TPS initiatives undertaken as a result of this Review, including, where applicable, both quantitative and qualitative evaluations.

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### **MATTHEW ROKE INQUEST RECOMMENDATIONS (2014)**

3. Police forces should develop protocols with local community and hospital mental health providers in order to facilitate the interaction with EDP and to improve the sharing of information regarding EDP in the community. Consideration should be given to utilizing crisis workers in interactions with EDP.

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### **JERMAINE ANTHONY CARBY INQUEST RECOMMENDATIONS (2016)**

11. The Peel Regional Police Service work with the RCMP Canadian Police Information Centre (CPIC) to study the possibility of enhancing information available to officers (i.e., information on warrants, prior occurrence details, mental health warnings, prior de-escalations, etc.).

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## **DAVID ANDREW DOUCETTE INQUEST RECOMMENDATIONS (2016)**

5. Consider building a repository of the locations of housing for those in need of social and psychiatric services and develop a process by which to access and disseminate the repository information at the time of dispatch.
6. Ensure that police officers are oriented to high risk housing locations within their assigned divisions.



## 4. THE SHARING OF INDIVIDUALIZED INFORMATION

In a number of instances, the police officers who attended on scene did not possess background information about the person in crisis or had limited information about them. For example, officers were unaware that the person had a history of mental health issues or what those issues were. Similarly, they were unaware of the person's particular diagnosis, what medications (if any) they had been prescribed or what supports may have already been in place. The absence of this information may have hindered the police in identifying the underlying problem being experienced by the person in crisis or what steps could be taken to assist them. Accordingly, some have suggested that this type of information should be more readily available to the police.

However, the sharing of such information engages important issues regarding patient privacy and civil liberties. An individual's personal medical history, whether it is physiological or psychological, is intensely private information. People who seek and obtain medical help are entitled to know that the information they share with their health care providers is confidential and strictly protected. The release of such information to the police could have a detrimental impact on their privacy interests, emotional stability and their willingness to seek medical assistance, without assurances of confidentiality.

As well, because stigma is still attached to people with mental health issues, concerns have been raised that sharing such information might contribute to further stigmatization of those with mental health issues and potential bias and/or discrimination by the police.

Thus, the question of whether a person's health information should be shared with the police is both complex and controversial. A number of juries have considered the issue and made recommendations.



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### **OTTO VASS INQUEST RECOMMENDATIONS (2006)**

22. The Empowerment Council should consider the possibility of providing a means of voluntarily sharing information with primary response teams, including police officers, which will enable psychiatric consumers and survivors to identify triggers and de-escalation techniques that are applicable in their own cases.

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### **JERRY KNIGHT INQUEST RECOMMENDATIONS (2008)**

3. To create a dispatch code, or call, to announce that officers are dealing with a subject whom they suspect is suffering from Excited Delirium and that EMS dispatch be notified.



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## **HAROLD JAMES MALTAR INQUEST RECOMMENDATIONS (2009)**

2. We recommend that the OPP initiate discussions with the RCMP and MCSCS concerning the criteria for inclusion of particular codes on the Canadian Police Information Centre database (CPIC). Specifically, we recommend that both police agencies and the Ministry review the criteria currently in place for entry of information concerning issues of mental illness or mental instability. This review should take into account the potential benefit for police officers and members of the public safety by providing as much information as possible about an individual, while balancing and being sensitive to the privacy concerns of individuals as well as applicable legislation concerning the protection and sharing of personal health information.

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## **BYRON RICHARD DEBASSIGE INQUEST RECOMMENDATIONS (2010)**

8. Subject to the laws of confidentiality and privacy, the Ministry of Health and Long Term Care, the Ministry of Community and Social Services, the Ministry of Community Safety and Correctional Services and any other Ministry which operates or governs facilities and social service programs, should develop plans which will foster the timely flow of records and information, on a free or cost recovery basis, between and amongst governmental and non-governmental agencies which are charged with, or involved in the field of providing social services to people with mental illness/disability and/or addiction within the criminal justice system.
10. The Ministry of Community Safety and Correctional Services should review CPIC to determine the feasibility of including a flag to indicate a mental illness diagnosis and to identify the client's probation/parole officer.

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## IACOBUCCI REPORT (2014)

1. The TPS create a comprehensive police and mental health oversight body in the form of a standing inter-disciplinary committee that includes membership from the TPS, the 16 designated psychiatric facilities, the three Local Health Integration Networks covering Toronto, Emergency medical Services, and community mental health organizations to address relevant coordination issues including:
  - a) Sharing Healthcare Information: developing a protocol to allow the TPS access to an individual's mental health information in circumstances that would provide for a more effective response to a person in crisis. This protocol must respect privacy laws and physician-patient confidentiality, and should address:
    - i. Whether, in consultation with the Government of Ontario, the concept of the "circle of care" for information sharing can be expanded to include the police, in circumstances beneficial to an individual's healthcare interests
    - ii. How healthcare, treatment and planning information with respect to people with repeated crisis interactions with the police can be shared with the TPS while respecting all relevant privacy and physician-patient confidentiality concerns
    - iii. More specifically, how healthcare information shared with the TPS can be segregated from existing police databases and therefore prevented from subsequently being passed on to other law enforcement, security and border services agencies. Healthcare information should continue to be treated as such, and not as police information.
  - b) Voluntary Registry: the creation of a voluntary registry for vulnerable persons, complementing the protocol recommended in a), which would provide permission to healthcare professionals to share healthcare information with the police, only to be accessed by emergency responders in the event of a crisis situation and subject to due consideration to privacy rights.

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## **MATTHEW ROKE INQUEST RECOMMENDATIONS (2014)**

6. The above named (Ministry of Community Safety and Correctional Services (MCSCS), Ontario Provincial Police (OPP), Ontario Association of Chiefs of Police (OACP), Ministry of Health and Long Term Care (MOHLTC), Information and Privacy Commissioner for Ontario) should produce an interpretation bulletin for police officers and mental health care providers in order to clarify the privacy issues in regard to the sharing of information between police and mental health care providers. This interpretation should focus on the health and safety of the individual whose information is being shared and on public safety.

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## **DOUGLAS CLIVE MINTY INQUEST RECOMMENDATIONS (2014)**

3. The Ontario Provincial Police ensure that all applicable policies, operational procedures and training for communications operators:
  - a) Requires that the call taker make further inquiries where a caller indicates that a mentally ill or emotionally disturbed or developmentally disabled person may be involved in the incident the police will be responding to
  - b) Communicate all relevant information with respect to potential interactions with mentally ill or emotionally disturbed or developmentally disabled individuals to the police officers responding to the call for service.
8. The Government of Ontario consider the establishment of a voluntary registry for vulnerable persons with due consideration to privacy interests and concerns. Such registry would only be accessible to emergency responders in the event of a crisis situation. Effort should be made to promote the registry within community organizations to encourage adoption.

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### **ANDREAS UNKERSKOV-CHINNERY INQUEST RECOMMENDATIONS (2016)**

11. Increased and ongoing training for communications branch to ensure clear, effective and efficient information is relayed from dispatcher to police based on information provided from call taker.

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### **DAVID ANDREW DOUCETTE INQUEST RECOMMENDATIONS (2016)**

4. Conduct a review as to whether specific types of health information should be provided to police services, who are frequently the first to have contact with an individual. Information to consider as part of the review may include information that may cause an individual to be a risk to others. The review should include consultation with relevant stakeholders and include consideration of the best away to make the information available in a timely manner.



## 5. POLICE CULTURE

Justice Iacobucci devoted an entire chapter of his report to police culture (Chapter 5). While recognizing many positive features of police culture, Justice Iacobucci also identified areas for improvement. One of the changes he proposed was a revised, transparent and progressive commitment by the police to foster a better understanding of, and relationship with, the mental health community and persons in crisis. To that end, he recommended that the Toronto Police Service prepare a formal statement setting out the service's commitments to people in crisis and to people experiencing mental health issues. His recommendations were as follows:

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### IACOBUCCI REPORT (2014)

5. The TPS prepare a formal statement setting out the Service's commitments relating to people in crisis and, more broadly, relating to people experiencing mental health issues. The statement should be made public and treated as of equal weight to the Services' Core Values. Among the commitments listed, the Service should consider including the following items:
  - a) A commitment to preserving the lives of people in crisis if reasonably possible, and the goal of zero deaths
  - b) A commitment to take all reasonable steps to attempt to de-escalate potentially violent encounters between police and people in crisis
  - c) A commitment by the Service to continuous self-improvement and innovation relating to issues of policing and mental health
  - d) A commitment to eliminating stereotypes and providing education regarding people with mental health issues



- e) A commitment to involving people with mental health issues directly, where appropriate, in initiatives that affect them, such as police training, and the development of relevant police procedures
- f) A commitment to working collaboratively with participants in the mental health system (individuals, community organizations, mental health organizations and hospitals)
- g) A commitment to institutional leadership in the area of policing and mental health, and to becoming a pre-eminent police service in this field
- h) A commitment to fostering a positive mental health culture within the TPS.



## 6. THE RECRUITMENT AND HIRING OF POLICE OFFICERS

Police services across the province, and the larger community, want to ensure that the new officers who are being recruited and hired have all of the necessary skills and qualifications to deal with the many challenging problems they face. This includes, of course, how to calmly and effectively work with persons in crisis to try to ensure a peaceful outcome. It has been recommended that police services place increased emphasis on recruiting and hiring police officers who have the appropriate skills to assist persons in crisis. To that end, certain recommendations have been proposed, most forcefully and recently by Justice Iacobucci.

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### IACOBUCCI REPORT (2014)

6. The TPS change mandatory application qualifications for new constables to require the completion of a Mental Health First Aid course, in order to ensure familiarity and some skill with this core aspect of police work.
7. The TPS give preference or significant weight to applicants who have:
  - a) Community Service: engaged in significant community service, to demonstrate community-mindedness and the adoption of a community service mentality. Community service with exposure to people in crisis should be valued
  - b) Mental Health Involvement: past involvement related to the mental health community, be it direct personal experience with a family member, work in a hospital, community service, or other contributions
  - c) Higher Education: completed a post-secondary university degree or substantially equivalent education.

8. The TPS amend its application materials and relevant portions of its website to ensure that applicants for new constable positions are directed to demonstrate in their application materials any qualifications relevant to Recommendation 7.
9. The TPS consider whether to recruit actively from certain specific educational programs that teach skills which enable a compassionate response to people in crisis, such as nursing, social work, and programs relating to mental illness.
10. The TPS direct its Employment Unit to hire classes of new constables that, on the whole, demonstrate diversity of educational background, specialization, skills, and life experience, in addition to other metrics of diversity.
11. The TPS instruct psychologists, in carrying out their screening function for new constable selection, to assess for positive traits, in addition to assessing for the absence of mental illness or undesirable personality traits. In this aim, the TPS, in consultation with the psychologists, should identify a specific set of positive traits it wishes to have for new recruits and should instruct the psychologists to screen-in for those traits.
12. The TPS include the psychologists in the decision making process for new constable selection, in a manner similar to their involvement in selecting officers for the ETF.
13. The TPS compile data to allow the Service to evaluate the effectiveness of the psychological screening tests that it has used in selecting recruits. Relevant data may include data that show what test results correlate with officers who have satisfactory and unsatisfactory interactions with people in crisis.



14. The TPS strike a working group that includes participation from the TPS Psychological Services unit to comprehensively consider the role of Psychological Services within the TPS, including:
  - a) More Information: whether the current process for psychological screening of new constables is effective and whether it could be improved, including whether TPS psychologists should be given more information about candidates to assist them in interpreting their test results
  - b) Involvement of Psychologists in other Promotion Decisions: whether Psychological Services should be authorized to conduct evaluations of, and otherwise be involved in, discussions regarding the selection processes for officer promotions within the Service, and the selection of coach officers
  - c) MCIT: whether the TPS psychologists should be involved in the selection and training of officers and nurses for the MCIT. More broadly, the TPS should consider how to facilitate a close and ongoing relationship between the psychologists and the MCIT in order to enable collaboration and information sharing between the Service's two units with a primary focus on mental illness
  - d) Organizational Structure: whether the TPS should amend its organizational structure so that Psychological Services reports directly or on a dotted-line basis to a Deputy Chief, in order to give greater recognition to the operational role that they play
  - e) Expanding Psychological Services: how Psychological Services should be expanded to accommodate the officer selection duties and TPS members' wellness needs, as described in this Report.



## 7. POLICE TRAINING

Perhaps the most common issue identified by coroner's juries has been that of police training. In many instances, the jury was of the view that enhanced training for police officers on issues related to mental health and assisting people in crisis would be beneficial. Improved training for police officers focusing on identifying the symptoms of a person in crisis, containment, communication and de-escalation, rather than the use of force has been recommended repeatedly. It has also been recognized that training curricula should be developed and taught with the involvement of people who have real expertise in the field of mental health, including consumers of the mental health system and medical professionals. Numerous juries have also recommended that the facts of the specific death that led to that particular inquest be used in training officers.

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### WINSTON GROSVENOR INQUEST RECOMMENDATIONS (1996)

1. Ensure that all arresting officers be cautioned against creating unnecessary tension and/or aggravation while apprehending subjects displaying symptoms of excited delirium.
4. We strongly recommend to reinforce continual training using "shams" from actual occurrences experienced; by officers in the performance of their duties. (shams: simulations)

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### **SCOTT ANDREW AMBEAULT INQUEST RECOMMENDATIONS (1996)**

1. We recommend that the OPP provide a training video to alert officers to the recognition of the symptoms of excited delirium and the use of physical restraint. This video should also alert them to the differences between persons with violent delirium and violent persons.

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### **EDMOND WAI-KONG YU INQUEST RECOMMENDATIONS (1999)**

11. The Solicitor General should amend the Police Services Act to require annual Crisis Resolution training, of at least one day, in addition to annual use of force training. Priority should be given to front line officers; however, this training should be delivered to command officers and senior managers as well.
12. The Crisis Resolution Course should have the input of mental health professionals, consumer survivor and multicultural groups, and should include, but not be limited to, the following issues:
  - a) Every opportunity should be taken to convert an unplanned operation into a planned operation
  - b) Unless impractical to do so, a “cordon and containment” approach should be adopted
  - c) That the aim of crisis resolution should be de-escalation and the resolution of situations without physical force
  - d) That the “first contact” and “time, talk, and tactics” approach be used by police whenever possible and that “active listening” be stressed as a skill that officers must develop
  - e) The fear and apprehension experienced by officers as a result of previous experiences, stereotyping or lack of knowledge, whether about mental illness, race, culture or other factors

- f) The fear and apprehension which persons involved with the police may feel as a result of previous experiences, stereotyping or lack of knowledge, particularly due to mental illness, racial or cultural background
  - g) That police officers, whenever possible, should maintain a sufficient reactionary gap to give them the time to disengage, tactically reposition themselves and or react in such a way which prevents a situation from escalating from the verbal to the violent.
- 13. That the five-day Crisis Resolution course be offered as a training course at C.O. Bick College until all existing officers are trained.
  - 16. That the C.O. Bick College evaluate the Crisis Resolution training to determine its effectiveness. The evaluation should include survey research, detailed interviews and/or performance appraisals of a proportion of graduate officers.
  - 17. Continue decentralized training, using Live-Link or other approved methods, at those divisions that are determined to have a proportionately high concentration of emotionally disturbed persons.
  - 18. That the Toronto Police Service follow the lead of the 57 other police forces in Ontario who have joined the Video Training Alliance in order to provide better decentralized training to its officers.
  - 19. That the Toronto Police Service and the Ontario Police College establish a closer working relationship to facilitate the baring of information, training expertise, and professional exchanges to avoid unnecessary duplication or delivery of conflicting training programs.

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### **DAVID NEIL SCHLAHT INQUEST RECOMMENDATIONS (1999)**

1. Police services provide ongoing in-service training to all personnel in dealing with individuals in an extreme agitated state caused by alcohol, drugs or a mental illness.
2. Such in-service training would include:
  - a) The recognition of the signs of an individual in an extreme agitated state
  - b) The awareness of the possible sudden onset of a potential respiratory and/or cardiac problem
  - c) A protocol for assessing ambulance and/or medical services
  - d) A review of the procedures for dealing with an extremely agitated person.
3. Such in-service should include input from survivors of the related condition, professionals, and caregivers.

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### **WAYNE RICK WILLIAMS INQUEST RECOMMENDATIONS (2000)**

7. It is recognized that the Toronto Police Services Board and the Chief of Police have made the Crisis Resolution Course mandatory for all officers since March of 1999 and that officers have continued to be trained since that time. We suggest that the Board and the Chief assign a high priority to the continued delivery of this course until all officers have been trained. We also recommend the implementation of an ongoing mandatory refresher course.

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## **NICHOLAS BLENTZAS INQUEST RECOMMENDATIONS (2005)**

1. That the Chief of Police of the Toronto Police Service and Toronto Police Services Board:
  - i. Enhance and continue to ensure that new recruits are taught:
    - a) The signs and symptoms of excited delirium
    - b) That excited delirium constitutes a medical emergency
    - c) The risks associated with the physical restraint of persons experiencing an episode of excited delirium.
  - ii. Enhance and continue to ensure that all police officers and court officers receive a yearly refresher, during their training on oleoresin capsicum (pepper spray), emphasizing:
    - a) The signs and symptoms of excited delirium
    - b) That excited delirium constitutes a medical emergency
    - c) The risks associated with the physical restraint of persons experiencing an episode of excited delirium.
2. That the Ontario Police College:
  - i. Enhance and continue its efforts to ensure that new recruits are taught:
    - a) About the signs and symptoms of excited delirium;
    - b) That excited delirium constitutes a medical emergency; and
    - c) The risks associated with the physical restraint of persons experiencing an episode of excited delirium.
  - ii. It is recommended that the Ontario Police College enhance and continue to include in the training program the practice of requiring all healthy trainees to experience firsthand the process of being physically restrained in the prone position.
3. That the Ontario Police College, the Chief of Police of the Toronto Police Service and the Toronto Police Services Board:

Consider the inclusion of the facts surrounding Nicholas Blentzas' death in the scenario role-playing exercises or case studies they

use to train officers on excited delirium. Any such reference to the facts in this case shall ensure complete anonymity on behalf of Nicholas Blentzas.

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### **PETER LAMONDAY INQUEST RECOMMENDATIONS (2005)**

6. The Ministry of Community Safety and Correctional Services, the Ontario Police College and all Municipal and Regional Police Services in the province of Ontario should continue to ensure that all police officers under their supervision receive up to date training with respect to restraint techniques and the risks associated with the restraint of individuals in various positions.
7. The Ministry of Community Safety and Correctional Services and the Ontario Police College and all Municipal and Regional Police Services in the province of Ontario should continue to ensure that all police officers under their supervision receive up to date training with respect to the signs and risks of excited delirium.

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### **OTTO VASS INQUEST RECOMMENDATIONS (2006)**

8. The Ministry of Community Safety and Correctional Services and Municipal and Regional Police Services in the Province of Ontario should ensure that the training police officers receive in mental health issues be improved by including some active participation of members of the psychiatric consumer/survivor community in the training process. This training should be included as part of the Basic Officer Training course at the Ontario Police College. On-going annual training should also include psychiatric consumer/survivor community participation where possible.
10. The Toronto Police Service and Toronto Police Services Board should consider studying the concept of rotating “front-line” police officers

through the special Mobile Crisis Teams in order to provide first-hand experience to as many officers as possible.

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### **O'BRIEN CHRISTOPHER-REID INQUEST RECOMMENDATIONS (2007)**

- 1 a) The Toronto Police Service to include greater emphasis in its training of new police recruits and in its annual use of force requalification training:
  - i. De-escalation techniques to include opportunities to initiate soft communication approaches when situations warrant
  - ii. Interactions with emotionally disturbed persons
  - iii. Racial diversity issues.
- b) The events leading up to the death of Mr. Christopher-Reid, be implemented for scenario-based training to new police recruits and in yearly use of force requalification training for police officers.
2. The Toronto Police Service continue to seek input from experts in the field of mental health and from consumer survivors groups, to develop new training initiatives and methods of delivery of their training programs. Upon completion of the training program, a variety of evaluative tools should be applied to assess understanding of the material presented.

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### **JASON EARL STEACY INQUEST RECOMMENDATIONS (2008)**

2. That the circumstances surrounding the death of Jason Steacy be adapted and incorporated into training exercises as deemed appropriate by persons of expertise. This may include scenario-based training, case studies and classroom exercises.



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### **JERRY KNIGHT INQUEST RECOMMENDATIONS (2008)**

4. To reinforce, through regular and refresher training, the risk of death associated with the use of prone restraint and the Hog-tying restraint.
5. To encourage increased research and training in excited delirium and restraint; including, the advisability of using the Taser in drive stun mode and pepper spray.
7. To reinforce, through regular and refresher training, the risk of death associated with the use of neck restraint techniques.

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### **MICHAEL DOUGLAS INQUEST RECOMMENDATIONS (2008)**

5. Police agencies should assess the feasibility of increasing the level of annual training for front line police officers with a consideration to training in mental health issues.

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### **JAMES FOLDI INQUEST RECOMMENDATIONS (2009)**

4. It is recommended that any updated or new information, as the result of the study of excited delirium, be promptly distributed to all police services in Ontario.

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### **HAROLD JAMES MALTAR INQUEST RECOMMENDATIONS (2009)**

1. We recommend that the OPP and the OPC consider developing a training scenario based on the circumstances of the death of Harold James Maltar, so officers and recruits can benefit from dealing with similar situations in a controlled training environment.

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## **BYRON RICHARD DEBASSIGE INQUEST RECOMMENDATIONS (2010)**

14. The Ministry of Community Safety and Correctional Services should revisit the benefits of having the portion of the curriculum dealing with mental health issues taught by a mental health professional.
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## **LEVI SCHAEFFER INQUEST RECOMMENDATIONS (2011)**

6. The Ministry of Safety and Correctional Services should consult with relevant professionals to assess the need for officers to receive further ongoing training on the recognition of and intervention with individuals who are emotionally disturbed/mentally ill.
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## **SEAN REILLY INQUEST RECOMMENDATIONS (2011)**

1. To reinforce and identify, through regular and refresher training, at least annually, the signs and symptoms of excited delirium, that excited delirium is a medical emergency, the risk of death associated with excited delirium and the importance of an immediate response in cases of suspected excited delirium.
2. To encourage the development of procedures whereby recommendations of a Coroner's Jury are disseminated to first responders through annual training.
6. To encourage the prompt distribution of any new or updated information acquired as a result of any study of excited delirium to all police services in Ontario.

7. To reinforce through training the importance of transfer of all information relevant to the care of an individual in custody between responding officers, arresting officers, staff sergeants in-charge, and cell officers.

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### **EVAN THOMAS JONES INQUEST RECOMMENDATIONS (2012)**

8. To ensure that all front-line personnel (including communications and dispatch personnel) have sufficient knowledge and skill to deal with issues relating to persons with mental illness, enhance and continue to ensure that all staff receive mandatory up-to-date training that is consistent with the standards set out in the Policing Standards Manual (2000), “Police Response to Persons who are Emotionally Disturbed or have a Mental Illness or a Developmental Disability” and the principles set out in the Contemporary Policing Guidelines for Working with the Mental Health System. Training should include information with respect to:
  - a) The understanding and identification of mental illnesses
  - b) How to communicate with persons with mental illnesses
  - c) Issues related to stigma
  - d) The importance of obtaining information from family members relating to the person with mental illness
  - e) The importance of providing all information relating to the mental health issues of person in their custody to health care professionals who are responsible for their treatment
  - f) How and where to access community mental health services available in jurisdiction.
9. To ensure that the appropriate resources and level of response required are known in advance of police attendance, enhance and continue to ensure that all communications and dispatch personnel receive mandatory up-to-date training with respect to:

- a) Making the necessary inquiries during the initial call to police to determine if mental illness may be a factor
  - b) Making the necessary checks of the SIP portion of CPIC; NICHE; and CAD to determine if there are any flags relating to suicide risk, mental health issues, or special situations.
10. To ensure that the appropriate flags in relation to suicide risk, mental health issues, or special situations must be entered into the SIP portion of CPIC; NICHE; and CAD, enhance and continue to ensure that all sworn police officers receive mandatory up-to-date training with respect to:
- a) The categories for flagging
  - b) The procedure and importance of flagging on the SIP portion of CPIC
  - c) The procedure and importance of flagging on NICHE
  - d) The procedure and importance of entering information relating to Special Situations associated with certain addresses
  - e) The development of a simplified process (i.e. a common form) for the request of the addition of flags to NICHE, CAD and the SIP portion of CPIC.
12. The jury supports and endorses the ministry's proposed review of how police interact with persons with mental illness. To ensure consistent evidence-based practice across the province and to prevent negative outcomes as a result of police interactions with persons with mental illness, the proposed review should include:
- a) A study of the feasibility of all "front line" or "primary response" police officers being trained and authorized to carry a conducted energy weapon or "Taser"
  - b) A study of the present curriculum offered by the Ontario Police College relating to police interactions with persons with mental illness
  - c) A review of the current Use of Force Model to determine if revisions are required based on current evidence-based best practice guidelines

- d) A review of the current standards for tactical communication and the use-of-force “police challenge” to develop evidence-based best practice guidelines where applicable and if appropriate
- e) Consultation with, among others, the Centre for Addiction and Mental Health, the Mental Health Commission of Canada; the Canadian Mental Health Association; the Canadian Association of Chiefs of Police; the Ontario Association of Chiefs of Police; and community mental health care providers.

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### **ARON JAMES FIRMAN INQUEST RECOMMENDATIONS (2013)**

- 13. Provide additional and meaningful awareness training for officers dealing with persons affected by mental illness, with particular attention to the concept and features of Excited Delirium Syndrome (ExDS), as part of annual Block Training. Providing mandatory e-learning opportunities, webinars and podcasts would assure consistency of messaging and mitigate the need for time away from front line duties as electronic availability does not require multiple officers to be in the same place at the same time.
- 14. Any suspicion by officers that a subject may be experiencing ExDS should be treated as a medical emergency and Emergency Medical Services (EMS) requested immediately.
- 15. Develop a standardized mental health screening form that includes the features of ExDS to assist officers in accurately reporting their observations and give consideration to when that form should be completed.



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### **JARDINE-DOUGLAS, KLIBINGAITIS, ELIGON INQUEST RECOMMENDATIONS (2014)**

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
    - 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 judgment skills they demonstrate in training and while on duty should also be developed.
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
    - 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.
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.
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.



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.
23. OPC and TPC shall consider expert review and analyses of videos, audios and evidence specific to each case, i.e., Sylvia Klibingaitis, Reyah Jardine-Douglas, Michael Eligon, for the purpose of identifying all alternative police service tactics for preserving life.
25. Consider providing officer with strategies to reduce immediate shock/adrenaline rush.
26. Incorporate more dynamic scenarios in use of force training (e.g., include bystanders, traffic and distractions).
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.
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.

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## **CHARLES MCGILLIVARY INQUEST RECOMMENDATIONS (2014)**

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
  - b) Guidelines for officers in terms of 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.
6. Enhance the Chief of Police's "Section 11 Reports" to the Toronto Police Services Board 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.
8. Study the incorporation of dynamic, scenario-based training that involves officers practicing ground pins against resisting subject when paired with a partner.

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## **IACOBUCCI REPORT (2014)**

15. The TPS place more emphasis in its recruit training curricula on such areas as:
  - a) Containment: considering and implementing techniques for containing crisis situations whenever possible in order to slow down the course of events and permit the involvement of specialized teams such as ETF or MCIT as appropriate
  - b) Communication and De-escalation: highlighting communication and de-escalation as the most important and commonly used



skills of the police officer, and the need to adjust communication styles when a person does not understand or cannot comply with instructions

- c) Subject Safety: recognizing the value of the life of a person in crisis and the importance of protecting the subject's safety as well as that of the officer and other members of the public
- d) Use of Force: making more clear that the Use of Force Model is a code of conduct that carries (i) a goal of not using lethal force and (ii) a philosophy of using as little non-lethal force as possible; and that the Model is not meant to be used as a justification for the use of any force
- e) Firearm Avoidance: implementing dynamic scenario training in which a recruit does not draw a firearm, as a means of emphasizing the non-lethal means of stabilizing a situation and reducing the potential for over-reliance on lethal force
- f) Fear: including discussions of officers' fear responses during debriefings of practical scenarios that required de-escalation and communication techniques to defuse a crisis situation

- g) Stigma: addressing and debunking stereotypes and stigmas concerning mental health. For example, the Toronto Police College (TPC) could build on its use of video presentations involving people with mental health issues by adding interviews with family members of people who have encountered police during crisis situations and police officers who were present during a crisis call that resulted or could have resulted in serious injury or death
  - h) Experience and Feedback: incorporating mental health and crisis situations into a larger number of practical scenarios to provide Police Encounters With People in Crisis recruits with more exposure to, and feedback on, techniques for resolving such situations
  - i) Culture: laying the foundation for the culture the TPS expects its officers to promote and embody, and preparing recruits to resist the aspects of the existing culture that do not further TPS goals and values with respect to interactions with people in crisis.
16. The TPS consider whether officers would benefit from additional tools to assist them in responding to crisis calls, such as a quick reference checklist for dealing with people in crisis that reminds officers to consider: whether the person is demonstrating signs of fear versus intentional aggression; whether medical, background and family contact information is available; whether alternative communication techniques are available when initial attempts at de-escalation are unsuccessful; whether containment of the person and the scene is a viable option; and whether discretion should be used in determining whether to apprehend, arrest, divert or release the person in crisis.
17. The TPS consider whether the 20-week recruit training period should be extended to allow sufficient time to teach all topics and skills required for the critically important work of a police officer.
18. The TPS consider placing more emphasis, within the existing time allocated to in-service training if necessary, on the areas identified in Recommendation 15.

19. The TPS consider requiring officers to re-qualify annually or otherwise in the areas of crisis communication and negotiation, de-escalation and containment measures.
20. The TPS consider whether to tailor in-service mental health training to the needs and experience levels of different audiences, such as by offering separate curricula for officers assigned to specialty units or divisions with high volumes of crisis calls.
21. The TPS consider how decentralized training can be expanded and improved to focus on such issues as:
  - a) Platoon training: increasing opportunities for officers to engage in traditional and online mental health programming within their platoons
  - b) Exposure: providing officers with in-service learning exercises that involve direct contact with the mental health system and community mental health resources
  - c) Peer learning: instituting a model of peer-to-peer education within divisions, such as discussions with officers who have experience with mental health issues in their families, who have worked on an MCIT, who received Crisis Intervention Team (CIT) training, or who have other related experience.
22. The TPS collaborate with researchers or sponsor research in the field of police education to develop a system for collecting and analyzing standardized data regarding the effectiveness of training at the TPC, OPC and the divisional levels, and to measure the impact that improvements in training have on actual encounters with people in crisis.
23. The TPS consider whether a broader range of perspectives can be considered in designing and delivering mental health training, for example, by involving TPS psychologists, Police College trainers, additional consumer survivors, mental health nurses and community agencies who work with patients and police.

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### **MATTHEW ROKE INQUEST RECOMMENDATIONS (2014)**

1. The MCSCS and OPC should fund and/or perform further research into the effective training of police officers in regard to interaction with emotionally disturbed persons (EDP).
2. The OPC and police forces should increase the mental health component of training of police officers in regard to illnesses and interaction with EDP. This training should be included in the annual mandatory training of police officers and should emphasize techniques of de-escalation, with consideration given to a behaviour management system model.

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### **DOUGLAS CLIVE MINTY INQUEST RECOMMENDATIONS (2014)**

1. The Ontario Provincial Police ensure the training for communications operators includes information relating to persons who are mentally ill, emotionally disturbed or developmentally disabled.
2. The Ontario Provincial Police ensure that all communications operators have completed all required training.
4. The Ontario Provincial Police review existing policies, procedures and training:
  - a) To ensure that they appropriately address police response to individuals with developmental disabilities
  - b) Clarify that a two-officer response is required in all situations involving mentally ill, emotionally disturbed or developmentally disabled individuals, unless there are exigent circumstances.
5. The Ontario Provincial Police ensure that scenario-based training programs address recognition and response to individuals with developmental disabilities as a separate and distinct group.

7. Serious use-of-force incidents, including those that result in death, be integrated into scenario-based training as case studies for both officers and communications officers.

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### **ANDREAS UNKERSKOV-CHINNERY INQUEST RECOMMENDATIONS (2016)**

12. Review (capture) or study the use of force cases dealing with persons in crisis to identify future training opportunities for patrol officers and the communication branch.
17. Consider incorporating this case as a scenario learning tool at the Hamilton Police Service Training Facility in order to exercise and solidify officer skills in de-escalation.
18. Consider scenario training in the area of disarming techniques involving an armed subject (non-firearm related).

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### **IAN GLENDON PRYCE INQUEST RECOMMENDATIONS (2016)**

2. The training of police officers should include the following: In situations in which a person contained by police officers is refusing to surrender but provides the name of a third party, the officers should immediately initiate an investigation, to determine if the third party can provide information and/or assistance that might help to resolve the situation.
3. The training of police officers with respect to negotiations should include the following: In situations in which police officers recognize that there is a realistic possibility that they might employ lethal force against a person undergoing a mental health crisis who is contained by the officers, the officers should immediately seek assistance of a mental health professional.

4. Provide formal training in basic negotiations for all new and current police officers.
5. Upon joining the ETF individuals that demonstrate further interest and/or aptitude in negotiations should be provided with continuous advanced negotiator training such that each ETF team could have access to such a trained negotiator.

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### **JERMAINE ANTHONY CARBY INQUEST RECOMMENDATIONS (2016)**

1. Consider using the circumstances of this case as a training scenario to examine whether new recruits or experienced officers demonstrate awareness of issues regarding:
  - a) “Unconscious bias” in the exercise of police discretion concerning traffic stops
  - b) The application of the new provincial regulations regarding collection of identifying information
  - c) The most effective methods of de-escalation, if the need develops
  - d) Decision-making to select the lowest level of force appropriate if use of force should be required.
2. Provide specific training relating to situations involving persons with an edged weapon:
  - a) Where the person has failed to respond and/or comply with police commands (i.e., drop the knife) train officers to stop shouting those commands and to attempt different defusing communication strategies
  - b) Train officers in such situations to coordinate amongst themselves so that one officer can take the lead in communicating with the person so that not all officers are shouting simultaneously.
3. Consider the most appropriate methods (including external consultation) to measure whether the training has been effectively



delivered and absorbed by those receiving the training in recommendations one and two.

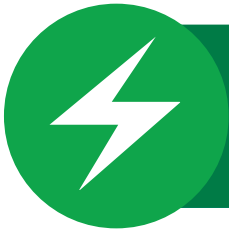
4. Develop a method to objectively measure the effectiveness of officer training (both initial and continuing) for unconscious bias, mental health issues, de-escalation and use of force. Officers should be tested, graded and must meet a benchmark in order to pass.
5. Provide new recruits and experienced officers with enhanced training regarding in cruiser databases such as the Canadian Police Information Centre (CPIC) and the information they contain.
6. Provide new recruits and experienced officers with additional training regarding effective communication of relevant CPIC and current situation information with other officers at the scene so that all officers share a common understanding of the situation and approach.
7. Provide new recruits and experienced officers with training on techniques for containing crisis situations whenever possible to slow down the course of events and permit involvement of specialized teams such as the Mobile Crisis Intervention Team if required.
8. Consider the most appropriate methods to determine and measure the application of training as set out in recommendations one and two when officers are performing their duties and interacting with the public.
9. Consider the most effective ways to enhance consultation or direct input by a cross-section of communities within Peel Region into the content and delivery of police training. By working with diverse populations within their community to build understanding and trust regarding communities' respective views on policing, police will be better equipped to exercise sensitivity and discretion concerning interactions with the public.

14. In conjunction with the Ontario Association of Chiefs of Police and the Ministry of Health and Long Term Care adapt the Training Standard and Crisis Intervention and De-escalation Model developed in British Columbia as the Training Standard and Crisis Intervention and De-escalation model for police services in the province of Ontario.

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### **DANIEL NICKOLAS CLAUSE INQUEST RECOMMENDATIONS (2016)**

2. Increase officers' awareness of Attention Deficit and Hyperactivity Disorder (ADHD) and other similarly classified mental impairments by including this subject matter in existing mental health training scenarios and considerations. This should include consultation and input from advocacy groups.
4. Reinforce the training of front line officers to advise supervisor via dispatch, when a call involves an armed subject, as soon as is practical on the scene.



## 8. CONDUCTED ENERGY WEAPONS (TASERS)

In a number of the cases reviewed by coroner's inquests, the issue of Tasers arose. In many instances, Tasers were not available or used, meaning that the police used their firearms instead. The end result was that someone died after having been shot by an officer. This has caused numerous coroner's juries to recommend the greater availability, and/or use of Tasers.

On the other hand, we know that people in Canada have died after having been shocked with a Taser.<sup>13</sup> In some of those instances, the police have been urged to study and/or curtail the use of Tasers until there is more data about the consequences of their use.<sup>14</sup> This, of course, leaves the police and the community with a great deal of uncertainty about the benefits or detriments of Tasers.

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### WAYNE RICK WILLIAMS INQUEST RECOMMENDATIONS (2000)

9. The Toronto Police Service should continue research and testing of non-lethal weapons and report developments annually to the Police Services Board. The Solicitor General should authorize the Toronto Police Service, in addition to the Ottawa Police Service, to conduct a pilot project regarding the operational capabilities and effectiveness of the M26 Taser.

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<sup>13</sup> Amnesty International has reported that between 2003 and 2007, 17 people in Canada died after having been Tasered. This includes, from our list of inquests, Peter Lamondy, Jerry Knight, James Foldi and Aron Firman. Riu Nabico died on November 4, 2016 after having been Tasered.

<sup>14</sup> In 2008, Amnesty International renewed its call for a moratorium on Taser use after a study by CBC. In 2013, the Council of Canadian Academies, in collaboration with the Canadian Academy of Health Sciences, issued a report concluding that better evidence is needed to understand the relationship between Tasers and other conductive energy weapons and adverse health effects.

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### **PETER LAMONDAY INQUEST RECOMMENDATIONS (2005)**

1. The Ministry of Community Safety and Correctional Services should take whatever steps are necessary to ensure all front-line police officers are authorized to carry a Taser.
2. Upon changes in legislation which would allow front line officers to use Tasers, the London Police Services should consider increasing the number of Tasers available to front line officers.
3. The Ministry of Community Safety and Correctional Services and Municipal and Regional Police Services in the province of Ontario who have adopted Taser use, must ensure that all police officers under their supervision receive training with respect to Taser use including the possible collateral risks to them by the use of a Taser during the course of attempts to effect control over a subject.
4. The Ministry of Community Safety and Correctional Services and all Municipal and Regional Police Services in the province of Ontario should ensure all officers authorized to use a Taser will continue to receive current information and training with respect to any new tactical uses of the device (e.g., through development of an Intranet site where police services view Taser use information from other municipalities).
5. The Ministry of Community and Correctional Services should develop a set of best practice guidelines for the use of Tasers in Ontario municipalities that have adopted this use of force option.

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### **OTTO VASS INQUEST RECOMMENDATIONS (2006)**

1. The Ministry of Community Safety and Correctional Services should take the necessary steps to ensure that all “front line” or “primary response” police officers are authorized to carry a Taser.

2. The Ministry of Community Safety and Correctional Services should develop a set of best practice guidelines for the use of Tasers for those Ontario police services that adopt this use of force option.
3. The Ministry of Community Safety and Correctional Services should consider restricting the use of the Taser to situations where the subject is assaultive and other immediate weapons are ineffective, or situations where there is risk of serious injury or bodily harm.
4. The Ministry of Community Safety and Correctional Services should make an effort to educate the public on the statistics of Taser use. Statistics should be made public and accessible.
5. The Ministry of Community Safety and Correctional Services and Municipal and Regional Police Services in the Province of Ontario, that have adopted Taser use, must ensure that all police officers under their supervision, and authorized to use a Taser, receive training with respect to Taser use. This training should be included as part of the Basic Officer Training course at the Ontario Police College. Training should include education as to the possible collateral risks, to officers and to members of the public, from the use of the Taser during the course of efforts to effect control over a subject.
6. The Ministry of Community Safety and Correctional Services and Municipal and Regional Police Services in the Province of Ontario that have adopted Taser use must ensure that as part of the annual ongoing officer training all officers continue to receive current information and training with respect to any new tactical uses of the device, as well as any new information as to the safety risks arising out of Taser use.
9. Upon the issuance of the necessary authorization by the Ministry of Community Safety and Correctional Services, the Toronto Police Service should provide Tasers to “front line” or “primary response” officers. The Tasers provided should include full accountability features including the video recorder.

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### **O'BRIEN CHRISTOPHER-REID INQUEST RECOMMENDATIONS (2007)**

8. The Toronto Police Service should immediately implement the use of Tasers for all primary response officers.

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### **JERRY KNIGHT INQUEST RECOMMENDATIONS (2008)**

6. To encourage all police services currently using Tasers to update their Taser technology.
14. To consider authorizing all front-line police officers to carry a Taser or have access to a Taser.

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### **MICHAEL DOUGLAS INQUEST RECOMMENDATIONS (2008)**

3. The Ministry of Community Safety and Correctional Services should assess the feasibility of all front-line police officers carrying conducted energy weapons.

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### **TREVOR COLIN GRAHAM INQUEST RECOMMENDATIONS (2009)**

4. That the use of Tasers by police services continue to be investigated as options for use by front line officers.

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### **JAMES FOLDI INQUEST RECOMMENDATIONS (2009)**

2. It is recommended that notification of product warnings and training memoranda respecting use of force options/equipment, including, but

not limited to, conducted energy weapons, such as Tasers, is promptly distributed to all members who are qualified and authorized to use such use of force options/equipment in their duties.

3. It is recommended that Taser qualification and annual re-qualification training courses also include judgment scenarios.

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### **HAROLD JAMES MALTAR INQUEST RECOMMENDATIONS (2009)**

7. That the OPP study the costs and benefits of expanding the policy, training and availability of conductive energy weapons for use by front-line officers.

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### **GINO PETRALIA INQUEST RECOMMENDATIONS (2011)**

5. The ministry should continue to explore the use of force option for all front line officers to carry Tasers.

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### **SEAN REILLY INQUEST RECOMMENDATIONS (2011)**

10. To encourage increased research and training in excited delirium and restraint, including the advisability of using the Taser in such cases.

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### **EVAN THOMAS JONES INQUEST RECOMMENDATIONS (2012)**

12. The jury supports and endorses the Ministry's proposed review of how police interact with persons with mental illness. To ensure consistent evidence-based practice across the province and to prevent negative outcomes as a result of police interactions with persons with mental illness, the proposed review should include:

- a) A study of the feasibility of all “front line” or “primary response” police officers being trained and authorized to carry a conducted energy weapon or “Taser.”

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### **ARON JAMES FIRMAN INQUEST RECOMMENDATIONS (2013)**

- 10. Revision of the provincially mandated Use of Force Report to include more comprehensive conducted energy weapon (CEW) deployment information, including degree of injury, location of probes (if so deployed) to allow for continued research as to whether or not any particular dart placement presents an increased risk for serious injury or death.
- 11. Consider collection and analysis of CEW deployment statistics from all police services in the province to be used to enhance or improve training, where indicated.
- 12. Liaise with other provinces and the RCMP to create a national database for all in-custody deaths, including those where a CEW was deployed, to enable further research into understanding the factors contributing to these sudden deaths.
- 17. Develop a central database for collecting data for CEW and other police use-of-force options with the intention of gathering statistics such as injuries/fatalities.
- 18. In circumstances where a subject becomes unresponsive after CEW deployment, officers need to contact EMS for assistance immediately.
- 19. Language in “Policing Standards Manual”, specifically Section 17(o) be changed to read: “probes imbedded in the chest area should be removed immediately by the member in order to begin Cardiopulmonary Resuscitation (CPR).” Members need to receive training in removal of probes, with the understanding that it is a relatively minor procedure without significant risk of further injury to the subject.



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## **JARDINE-DOUGLAS, KLIBINGAITIS, ELIGON INQUEST RECOMMENDATIONS (2014)**

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.
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
  - d) an electronic format for improved input and tracking.
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.
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.

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## **IACOBUCCI REPORT (2014)**

55. The TPS advocate an interprovincial study of the medical effects of conducted energy weapon (CEW) use on various groups of people (including vulnerable groups such as people in crisis), as suggested by the Goudge Report.

56. The TPS collaborate with other municipal, provincial, and federal police services to establish a central database of standardized information concerning matters related to the use of force, and CEW use specifically, such as:
- a) The location of contact by CEW probes on a subject's body
  - b) The length of deployment and the number of CEW uses
  - c) Any medical problems observed by the officers
  - d) Any medical problems assessed by Emergency Medical Services (EMS) or hospital staff
  - e) The time period between the use of a CEW and the manifestation of medical effects
  - f) The subject's prior mental and physical health condition
  - g) The use of CEWs per ratio of population
  - h) The use of CEWs per ratio of officers equipped with the devices
  - i) The use of CEWs in comparison to other force options.
57. The TPS review, and if necessary amend, the Use of Force and CEW Report forms to ensure that officers are prompted to include all standardized information required for the database proposed in Recommendation 56.
58. The TPS collaborate with Local Health Integration Networks, hospitals, EMS, and other appropriate medical professionals to standardize reporting of data concerning the medical effects of CEWs.
59. The TPS consider conducting a pilot project to assess the potential for expanding CEW access within the Service, with parameters such as:
- a) Supervision: at an appropriate time to be determined by the TPS, CEWs should be issued to a selection of front line officers in a limited number of divisions for a limited period of time with the use and results to be closely monitored
  - b) Cameras: all front line officers who are issued CEWs should be equipped either with body-worn cameras or audio/visual attachments for the devices;

- c) Reporting: the pilot project require standardized reporting on issues such as:
    - i. Frequency and circumstances associated with use of a CEW, including whether it was used in place of lethal force
    - ii. Frequency and nature of misuse of CEWs by officers
    - iii. Medical effects of CEW use
    - iv. The physical and mental state of the subject.
  - d) Analysis: data from the pilot project be analyzed in consideration of such factors as:
    - i. Whether CEWs are used more frequently by primary response units, as compared to baseline information on current use of CEWs by supervisors
    - ii. Whether CEWs are misused more frequently by primary response units, as compared to baseline information on current use of CEWs by supervisors
    - iii. The disciplinary and training responses to misuses of CEWs by officers and supervisors
    - iv. Whether use of force overall increased with expanded availability of CEWs in the pilot project
    - v. Whether use of lethal force decreased with expanded availability of CEWs in the pilot project
    - vi. Whether TPS procedures, training or disciplinary processes need to be adjusted to emphasize the objective of reducing deaths without increasing the overall use of force or infringing on civil liberties.
  - e) Transparency: the TPS report the results of the pilot project to the Toronto Police Services Board (TPSB), and make the results publicly available.
60. The TPS ensure that all CEWs issued to members (including those CEWs already in service) are accompanied by body-worn cameras, CEW audio/visual recording devices, or other effective monitoring technology.

61. The TPS ensure that CEW Reports are reviewed regularly, and that inappropriate or excessive uses are investigated.
62. The TPS discipline, as appropriate, officers who over-rely on or misuse CEWs, especially in situations involving non-violent people in crisis.
63. The TPS provide additional training, as appropriate, to officers who misuse CEWs in the course of good faith efforts to contain situations without using lethal force.
64. The TPS require officers to indicate on CEW Reports whether, and what, de-escalation measures were attempted prior to deploying the CEW.
65. The TPS carefully monitor the data downloaded from CEWs on a periodic basis, investigate uses that are not reported by service members and discipline officers who fail to report all uses appropriately.
66. The TPS periodically conduct a comprehensive review of data downloaded from CEWs and audio/visual attachments or body cameras, to identify trends in training and supervision needs relating to CEWs as well as the adequacy of disciplinary measures following misuse.
67. The TPS revise its CEW procedure to emphasize that the purpose of equipping certain officers with CEWs is to provide opportunities to reduce fatalities and serious injuries, not to increase the overall use of force by police.
69. The TPS consider the appropriate threshold for permissible use of CEWs, and in particular whether use should be limited to circumstances in which the subject is causing bodily harm or poses an immediate risk of bodily harm to the officer or another person, and no

lesser force option, de-escalation or other crisis intervention technique is available or is effective.

70. The TPS require that all officers equipped with CEWs have completed Mental Health First Aid or equivalent training in mental health issues and de-escalation techniques.

71. The TPS ensure that training on potential health effects of CEWs, including any heightened risks for people in crisis or individuals with mental illnesses, is updated regularly as the state of knowledge on the topic advances.

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#### **MATTHEW ROKE INQUEST RECOMMENDATIONS (2014)**

4. Police forces should increase the number of front line officers trained in the use of, and equipped with, conducted energy weapons (CEW).
5. Police forces should ensure, where possible, that CEW's are available in all interactions between police and persons with weapons other than firearms.

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#### **DAVID ANDREW DOUCETTE INQUEST RECOMMENDATIONS (2016)**

2. The Toronto Police Service should continue to explore the use of Conducted Energy Weapons by frontline officers who have been provided with proper training.



## 9. PEPPER SPRAY AND OTHER EQUIPMENT

Several coroners' juries have recommended the use of other police equipment as an alternative to the use of firearms or conducted energy weapons to decrease the risk of a fatal outcome.

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### ZDROVKO PUKEC INQUEST RECOMMENDATIONS (1996)

8. That police services continue to utilize pepper spray as a non-lethal use of force option.

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### PETER LAMONDAY INQUEST RECOMMENDATIONS (2005)

8. The Ministry of Health and Long Term Care and the Ministry of Community Safety and Correctional Services should conduct a study of municipalities where chemical restraints are administered at the scene for early intervention in situations involving suspected cases of excited delirium in order to determine if there is a benefit.
9. Based on the results of the study outlined in recommendation 8, police services, the ambulance services and emergency room clinical staff in London should collaborate to explore the possibility of using chemical restraint for the early intervention in situations involving suspected cases of excited delirium.

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### **OTTO VASS INQUEST RECOMMENDATIONS (2006)**

20. The Canadian Police Research Centre, National Research Council, and Ontario Ministry of Community Safety and Correctional Services should consider funding research into the potential benefits of equipping all police cruisers with defibrillators.

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### **JAMES FOLDI INQUEST RECOMMENDATIONS (2009)**

5. It is recommended that portable automatic external defibrillators (AEDs) be equipped in Supervisor vehicles and that all Supervisors and other appropriate personnel receive the necessary training to properly utilize AEDs.

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### **HAROLD JAMES MALTAR INQUEST RECOMMENDATIONS (2009)**

5. We recommend that the OPP study the costs and benefits of installing global positioning systems (GPS) technology in police cruisers to assist dispatchers and improve safety for officers and members of the public. The study might also consider the costs and benefits of officers carrying such a device as part of their equipment on their duty belt, since officers are often out of their cruisers and may be difficult to locate in remote parts of the province.



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### **JARDINE-DOUGLAS, KLIBINGAITIS, ELIGON INQUEST RECOMMENDATIONS (2014)**

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.



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## **IACOBUCCI REPORT (2014)**

74. The TPS conduct a review of alternative equipment options and tactical approaches, including examples from other jurisdictions, to assist in further reducing the number of deaths arising from police encounters with people in crisis.

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## **IAN GLENDON PRYCE INQUEST RECOMMENDATIONS (2016)**

8. A study should be undertaken to determine if improvements can reasonably be made in the technology available to enable negotiations to be heard by all officers involved in the incident and be recorded for use in future negotiation training. The study should include consideration of portable devices to allow remote communications at greater distances.
9. To study emerging less-lethal technology and consider making these tools available to the Emergency Task Force.



## 10. BODY-WORN AND IN-CAR CAMERAS

Many police services across Canada are considering using body-worn cameras. Proponents of body-worn cameras embrace the transparency and accountability that comes from being able to view a recording of the interaction between an officer and a civilian. This would be beneficial from a training perspective as the recordings could be used to review the interaction and learn from it. Body cameras would also help ensure that police conduct themselves in accordance with the law and they provide concrete evidence should the police engage in any wrongdoing. Moreover, proponents of body cameras also suggest that their use would benefit the police by protecting them against false allegations of misconduct or abuse.

Others worry about the loss of privacy for civilians when the police use body-worn cameras. However, given the potential benefits of these devices, both the Jardine-Douglas, Klibingaitis, Eligon Inquest and Justice Iacobucci recommended that their potential use be studied and evaluated.

In February 2015, the Toronto Police Service initiated a 12-month pilot project to explore the benefits of body-worn cameras for front-line officers. Between May 2015 and March 2016, 85 officers from four different units field-tested the system by wearing cameras on the front of their uniforms.

On September 15, 2016, the Toronto Police Service released its evaluation of the project. Despite some significant shortcomings (small sample size, insufficient battery life, corrupt video files), the TPS recommended that all of its officers be equipped with the cameras. The anticipated cost of doing so is \$85 million over ten years (not including administrative costs).

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## EVAN THOMAS JONES INQUEST RECOMMENDATIONS (2012)

15. For the purposes of quality assurance and to provide educational feedback to front-line officers, examine the feasibility of audio and/or video recordings of:
- a) All incidents
  - b) Critical incidents.

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## JARDINE-DOUGLAS, KLIBINGAITIS, ELIGON INQUEST RECOMMENDATIONS (2014)

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.)

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## IACOBUCCI REPORT (2014)

72. The TPS issue body-worn cameras to all officers who may encounter people in crisis to ensure greater accountability and transparency for all concerned.
73. The TPS develop a protocol for protecting the privacy of information recorded by body-worn cameras. The protocol should address the following matters:

- a) Use and Retention: The privacy protocol should address the appropriate methods of storage and length of retention of body camera recordings, limits to accessing and sharing this information, and mechanisms through which individuals recorded can request access to, and the deletion of, information stored by the TPS
- b) Discretion: The TPS should establish the scope of discretion for officers to disable recording, reporting measures to be taken when a camera is deactivated, and consequences of misusing that discretion. Examples include requiring officers to notify Communications Services of the reason for disabling a body camera and the duration of the deactivation, or requiring officers to file reports detailing any circumstances in which their body cameras were deactivated
- c) Discipline: The TPS should establish and enforce clear disciplinary measures for members of the service who do not comply with the privacy protocol and the discretionary/use protocol to be developed concerning body cameras
- d) Balancing Interests: The TPS should investigate appropriate options for balancing an individual's right to privacy, an officer's discretion, and the need for accountability in public policing
- e) Collaboration: The TPS should work closely with civil liberties groups, legal advisors, consumer survivors, provincial government agencies, privacy commissioners and other appropriate stakeholders in developing the protocol.

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## **ANDREAS UNKERSKOV-CHINNERY INQUEST RECOMMENDATIONS (2016)**

- 16. Consider investigating the use of wide angled lapel cameras for frontline officers in order to verify the event and gather more information about the interaction.



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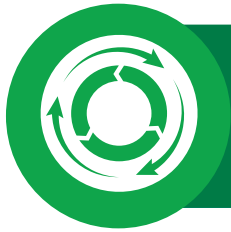
#### **JERMAINE ANTHONY CARBY INQUEST RECOMMENDATIONS (2016)**

10. Study and evaluate the feasibility of in-vehicle and/or body worn recording devices to document their interactions with the public.

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#### **DANIEL NICKOLAS CLAUSE INQUEST RECOMMENDATIONS (2016)**

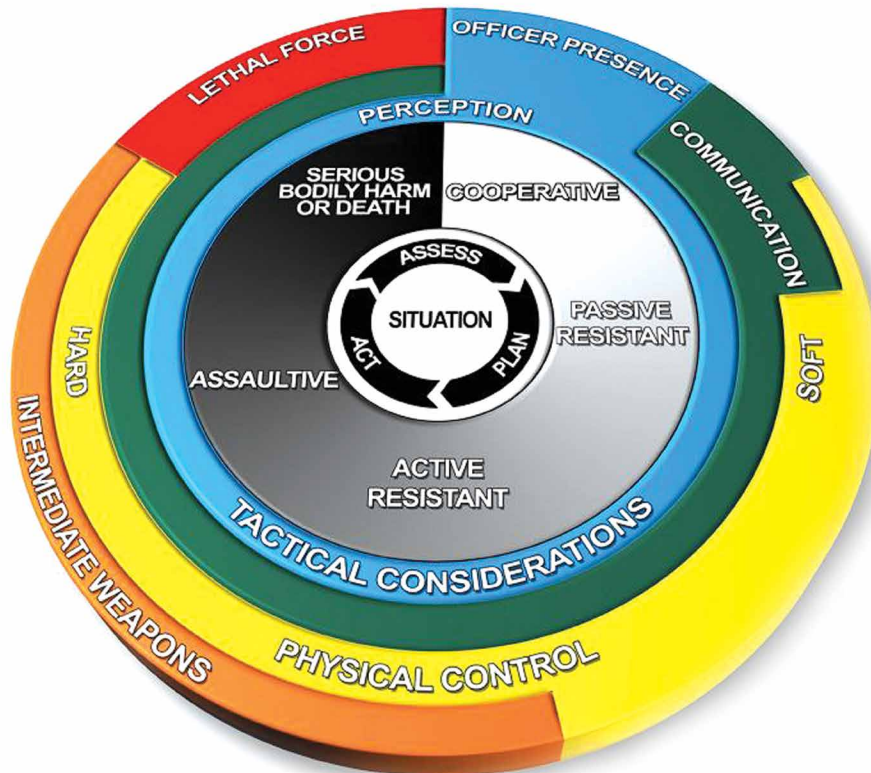
1. Encourage TPS to continue investigating the use of body cameras/ audio recording devices.



## 11. THE USE OF FORCE MODEL

A use of force framework is a standard that provides law enforcement officers and civilians with guidelines as to how much force may be used against a person resisting them in a given situation. Police services across Ontario currently employ the same use of force framework when interacting with persons in crisis as they do when interacting with people not in crisis. The specific model now in use by police was implemented in 2004. It provides the officer with a variety of options when considering the use of force, all of which are illustrated on a circular wheel. They include officer presence; communication; physical control (ranging from soft to hard techniques); the use of intermediate weapons such as batons, pepper spray and Tasers; and lethal force. The decision of which option to employ is guided by the degree of cooperation being exhibited by the person with whom they are interacting.

## Use of Force Model (2004)



The model directs that a police officer continually assess the situation and select the most reasonable option relative to the circumstances as perceived at that point in time. However, the use of force model currently employed in Ontario has been criticized by many as outdated and inflexible. Thus, several inquests and reports have recommended that it be updated and improved.

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### **WINSTON GROSVENOR INQUEST RECOMMENDATIONS (1996)**

1. Ensure that all arresting officers be cautioned against creating unnecessary tension and/or aggravation while apprehending subjects displaying symptoms of excited delirium.
2. We strongly recommend and emphasize that monitoring of vital signs commence immediately and be maintained constantly during transportation of subject at site.

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### **PETER LAMONDAY INQUEST RECOMMENDATIONS (2005)**

17. The Coroner's Office should update and reissue its memorandum #630 dated February 20, 1995, to police services, correctional services, ambulance services, security services, hospitals, psychiatric facilities and group homes, outlining the signs and symptoms of excited delirium and issues surrounding restraints. In addition, the Coroner's Office should consider developing or directing the development of guidelines or best practices for the management of individuals who are apparently experiencing excited delirium. Finally, the memorandum should direct individuals to available resources and information on excited delirium and restraint.

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### **O'BRIEN CHRISTOPHER-REID INQUEST RECOMMENDATIONS (2007)**

9. Any legislation and policies regarding the use of Force Report Form 1 be reviewed to consider whether part B should be retained for permanent police record.



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### **JASON EARL STEACY INQUEST RECOMMENDATIONS (2008)**

3. To conduct a periodic evaluation of rural policing in Ontario to ensure sufficient front-line officers are available at all times. If any opportunities for greater efficiency or improvements are identified, the necessary adjustments should be made as soon as is practical.
8. That the ministry examines any existing studies regarding how civilians react when confronted with the police challenge in a variety of circumstances, to ensure that current protocols are optimised. If existing studies are not considered relevant or adequate for situations that the police in Ontario are likely to encounter, then the ministry should consider commissioning and funding such a study.

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### **JERRY KNIGHT INQUEST RECOMMENDATIONS (2008)**

1. To provide hand restraint devices to all tactical, supervising and frontline officers which allow the subject to be restrained with the hands of the subject to the side of the hips.
8. To encourage the development of better forms of leg restraints and have all Police vehicles equipped with such device. (i.e., flexicuffs)
9. To encourage the development of a coordinated approach to rapidly restrain non-compliant subjects. (i.e., starfish technique)
10. If possible, when multiple Officers are dispatched, the more experienced officers should take the lead role in dealing with the situation. The senior officer in charge, or designate, should be responsible for communicating with officers newly arriving to the scene as to the status of the situation and remain on scene for the full duration.

11. Development of alternate standardized procedures to replace hog-tying and once these procedures are in place, hog-tying be banned altogether.
12. Development of procedures and policies for police officers to communicate to the subject during a violent struggle, to include instructions of a potentially hazardous or fatal outcome if resistance continues.

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### **JAMES FOLDI INQUEST RECOMMENDATIONS (2009)**

7. It is recommended that the Niagara Regional Police Services review General Order 053.08, dealing with Use of Force, including ongoing review, for the purpose of ensuring that it reflects the contents of any product warning or training memoranda respecting use of force options and/or equipment, including but not limited to Conducted Energy Weapons, such as Tasers.

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### **SEAN REILLY INQUEST RECOMMENDATIONS (2011)**

3. The development of a coordinated approach for policing and Emergency Medical Services first responders to rapidly restrain subjects displaying symptoms of excited delirium.
4. The development of a written coordinated protocol for policing and EMS first responders in situations of suspected excited delirium.
5. The development of procedures which will enhance and improve the transfer of information to and from policing and EMS first responders.
8. To encourage funding to enable the additional training of Advanced Care Paramedics and Tactical Paramedics.

9. To develop a protocol whereby Advanced Care Paramedics and/or Tactical Paramedics would attend wherever possible during cases involving subjects displaying symptoms of excited delirium.

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### **EVAN THOMAS JONES INQUEST RECOMMENDATIONS (2012)**

12. The jury supports and endorses the ministry's proposed review of how police interact with persons with mental illness. To ensure consistent evidence-based practice across the province and to prevent negative outcomes as a result of police interactions with persons with mental illness, the proposed review should include:
  - c) A review of the current Use of Force Model to determine if revisions are required based on current evidence-based guidelines.

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### **ARON JAMES FIRMAN INQUEST RECOMMENDATIONS (2013)**

10. Revision of the provincially mandated Use of Force Report to include more comprehensive conducted energy weapon (CEW) deployment information, including degree of injury, location of probes (if so deployed) to allow for continued research as to whether or not any particular dart placement presents an increased risk for serious injury or death.

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### **JARDINE-DOUGLAS, KLIBINGAITIS, ELIGON INQUEST RECOMMENDATIONS (2014)**

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.
31. Consider an improved, inter-operable 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.
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.

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### **IACOBUCCI REPORT (2014)**

41. The TPS revise its Use of Force Procedure to supplement the Ontario Use of Force Model and guidelines with best practices from external bodies such as the International Association of Chiefs of Police, the United Nations and other police services in order to:
  - a) Incorporate approaches to minimizing the use of lethal force wherever possible
  - b) Increase the emphasis placed on the seriousness of the decision to use lethal force in response to a person in crisis
  - c) Further emphasize lethal force as a last resort to be used in crisis situations only where alternative approaches are ineffective or unavailable
  - d) Articulate the importance of preserving the lives of subjects as well as officers wherever possible
  - e) Recognize indicators of mental health crises as symptoms rather than threats to officer safety
  - f) Acknowledge that many mental health calls result from crisis symptoms rather than criminal behavior
  - g) Emphasize that police responding to people in crisis are usually required to play a helping role, not an enforcement role

- h) Articulate that communication with a person in crisis should be a default technique in all stages of assessing and controlling the situation and planning a response.
42. The TPS regularly update its Use of Force Procedure to reflect best practices and the results of further research into the most effective means of communicating with people in crisis. In this regard, the TPS should seek alternative approaches for officers when a person in crisis does not appear to comprehend or have the ability to comply with the Police Challenge; and consider consulting with provincial agencies, the Ontario Police College, mental health experts, consumer survivors, and others with specialized experience to ensure that the Use of Force Procedure reflects best practices.

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### **IAN GLENDON PRYCE INQUEST RECOMMENDATIONS (2016)**

- 6. Amend the Communications High Risk Incident Procedure to require a dispatcher to verbally notify officers on scene of important information and verify acknowledgement.
- 7. Call-taker training should be enhanced to ensure that no suggestion be made to a caller that risks personal safety and to review the flow of information from call taker to dispatcher.



## 12. POLICE SUPERVISION

A number of inquests have recommended enhanced supervision at all stages of policing with respect to dealing with persons in crisis. They emphasize the need for supervisors that are better qualified and trained in relation to mental health issues and assisting persons in crisis, and for a greater degree of supervisor involvement in the training of officers.

Concerns have been raised, in particular, about the failure of police services to effectively debrief their officers after they have used force or been engaged in a fatal incident. This results in several negative consequences, including but not limited to:

- A failure to assist and support the officer who may be suffering from trauma
- A failure to analyze the events leading to the fatality, thereby missing an opportunity for the officer to be commended where appropriate or to learn from his/her mistakes
- A failure to track fatal incidents across the police service which precludes a better understanding of any patterns that may be present
- A failure to use each incident as a training and learning opportunity for the service as a whole.

Debriefing after such an event is critical for the well-being of the involved officer and the education of the service as a whole. A proper debriefing can assist the police to learn from their mistakes and better address a similar situation in the future. This, in turn, makes lethal outcomes less likely and the community safer. That is the primary goal of this systemic review. On that basis, a number of inquests and reports have recommended a more robust debriefing process for officers involved in fatal situations.

At the same time, these debriefings must be confidential and any information shared during the debriefing should not become evidence in any disciplinary proceeding against the officer. This will ensure that the involved officers can speak freely and honestly without fear that their statements will be used against them.

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### **O'BRIEN CHRISTOPHER-REID INQUEST RECOMMENDATIONS (2007)**

3. When an officer has been involved in an incident that results in serious injury or death, there must be a review of the incident by the Use of Force Review Committee. This includes a mandatory review of the officer's actions, to determine whether re-training of the officer is required before the officer resumes active police duties.

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### **JASON EARL STEACY INQUEST RECOMMENDATIONS (2008)**

7. That a review of counseling services available to OPP officers be conducted to ensure short-term and long-term support is available following incidents where an officer's direct or indirect involvement in the use of lethal force results in the death or disability of another person. Persons of expertise may wish to consider the inclusion of an officer mentoring opportunity for those who have experienced a traumatic event.

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### **MICHAEL DOUGLAS INQUEST RECOMMENDATIONS (2008)**

7. The Sarnia Police Service and police services generally should develop a mandatory protocol to ensure that a full departmental debrief occurs as soon as practical following a critical incident.
8. All agencies involved in a critical incident are encouraged to participate in a joint debrief.

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### **TREVOR COLIN GRAHAM INQUEST RECOMMENDATIONS (2009)**

5. That police services be directed to implement mandatory psychological assessments for officers involved in traumatic events and to offer appropriate support services.

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### **GINO PETRALIA INQUEST RECOMMENDATIONS (2011)**

1. Review the contents and manner of implementation of the Durham Region Critical Incident Stress Support Team Directive (DRCISST), to ensure that it incorporates and maintains best practices in the provision, delivery and follow up in the care of critical incident stress for all officers involved in critical incidents.

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### **JARDINE-DOUGLAS, KLIBINGAITIS, ELIGON INQUEST RECOMMENDATIONS (2014)**

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



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.

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.

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.

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### **IACOBUCCI REPORT (2014)**

24. The TPS further refine its selection and evaluation process for coach officers and supervisory officers to ensure that the individuals in these roles are best equipped to advise officers on appropriate responses to people in crisis; in particular, that the TPS:

- a) Consider requiring additional mental health training and/or experience for candidates interested in coach officer and sergeant positions, such as CIT training or MCIT experience
- b) Create an evaluation mechanism through which officers can provide anonymous feedback on their coach officers or supervisors, including feedback on their skills regarding people in crisis
- c) Ensure that performance evaluation processes for supervisors include evaluation of both their skills regarding mental health and crisis response, as well as their monitoring of their subordinates' mental health and wellness.

25. The TPS create a service-wide procedure for debriefing, including the debriefing of incidents involving people in crisis and incidents involving use of force, which includes consideration of such factors as:

- a) Discretion: the circumstances under which debriefing is mandatory, as opposed to when it is subject to the discretion of the appropriate supervisor
- b) Participants: which members should participate in the debriefing process, particularly where there is a risk of re-traumatizing an officer suffering from critical incident stress
- c) Institutional Learning: how the learning points from the debriefing can be shared with other members of the service
- d) Process: the appropriate circumstances, methods and selection of appropriate personnel for debriefing incidents that involved people in crisis, whether they were resolved successfully or resulted in unsatisfactory outcomes
- e) Timing: how to create an expectation that debriefs will be conducted immediately after an incident, where appropriate, to encourage learning through debriefs without the fear of resulting sanctions
- f) Self-analysis: whether the incident was resolved with the least amount of force possible, as well as whether the officer experienced fear, anxiety and other psychological and emotional effects during the encounter, and techniques for coping with those effects while trying to de-escalate a situation
- g) Direct Feedback: direct feedback to officers on incidents that could have been resolved with less or no force, including whether the officer considered inappropriate circumstances or failed to consider appropriate factors and any alternative force options that could have been employed
- h) Critical Incident Response: the importance of conducting debriefs in a manner that respects officers' mental health needs following an incident of serious bodily harm or lethal force, and the role of the Critical Incident Response Team
- i) Stigma: how to foster discussions regarding stereotypes or misconceptions about people in crisis that may have contributed to the officer's decision-making during the crisis situation
- j) Valuing the Role of Debriefs: methods for creating a culture of debriefing and self-assessment within the Service, rather than a systemic perception of debriefing as a routine administrative duty.

26. The TPS develop a procedure that permits debriefing to occur on a real-time basis despite the existence of a Special Investigations Unit (SIU) investigation. The TPS should work with the SIU and appropriate municipal and provincial agencies to craft a procedure that does not interfere with external investigations, and that maintains the confidentiality of the debriefing process in order to promote candid analysis and continuous education.
27. The TPS develop a network of mental health champions within the service by appointing at least one experienced supervisory officer per division with experience in successfully resolving mental health crisis situations to:
  - a) Provide formal and informal divisional-level training, mentoring and coaching to other officers
  - b) Lead or participate in debriefings of mental health crisis calls when appropriate
  - c) Provide feedback to supervisors and senior management on officers who deserve recognition for exemplary conduct when serving people in crisis and those who need additional training or coaching
  - d) Meet periodically with other mental health champions at various divisions to discuss best practices, challenges, and recommendations
  - e) Report to the appropriate deputy chief or command officer on the above responsibilities.
28. The TPS establish an appropriate early intervention process for identifying incidents of behaviour by officers that may indicate a significant weakness in responding to mental health calls. Relevant data would include: propensity to draw or deploy firearms unnecessarily; use of excessive force; lack of sensitivity to mental health issues; insufficient efforts to de-escalate incidents; and other behaviours.

29. The TPS review its discipline procedure with regard to the following factors:
- a) Consistency: whether appropriate consequences are consistently applied to penalize inappropriate behaviour by officers in connection with people in crisis
  - b) Appropriate Penalties: whether officers who demonstrate conduct inconsistent with the role of a police officer are appropriately disciplined, including through suspension without pay or removal from their positions when appropriate
  - c) Supervisory Responsibility: whether there are appropriate disciplinary consequences for supervisors who fail to fulfill their duties to identify and rectify weaknesses in training or performance by officers subject to their oversight
  - d) Use of Force Reports: whether the information recorded in previous Use of Force Reports could be used in determining the appropriate level of discipline in particular incidents involving excessive use of force
  - e) Legislative Reform: whether the factors listed above require the TPS to work with the provincial government to modify legislative or regulatory provisions.
30. The TPS create incentives for officers to put mental health training into practice in situations involving people in crisis, and to reward officers who effectively de-escalate such crisis situations. In this regard, the TPS should consider inviting community organizations or other agencies to participate in determining division-level and service-wide awards for exceptional communications and de-escalation skills.
31. The TPS consider revising the process for performance reviews and promotions to:
- a) Establish an explicit criterion that experience with people in crisis will be considered in making promotion decisions within the service
  - b) Place a greater emphasis on crisis de-escalation skills such as communication, empathy, proper use of force, patience and use of mental health resources

- c) Determine the appropriate use of information contained in Use of Force Reports in assessing an officer's performance and suitability for promotion or particular job assignments.
32. The TPS enforce, in the same way as other TPS procedures, those procedures that require an officer to attempt to de-escalate, such as Procedure 06-04 "Emotionally Disturbed Persons". In particular:
- a) Professional Standards investigations under Section 11 of Regulation 267/10 under the Police Services Act should investigate whether applicable de-escalation requirements were complied with and, if not, a finding of contravention of service governance and/or misconduct should be made
  - b) In appropriate cases, officers who do not comply with applicable de-escalation requirements should be subject to disciplinary proceedings
  - c) Supervisory officers should be formally directed to (i) monitor whether officers comply with applicable de-escalation requirements, and (ii) take appropriate remedial steps, such as providing mentoring and advice, arranging additional training, making notations in the officer's personnel file, or escalating the matter for disciplinary action.

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## **DOUGLAS CLIVE MINTY INQUEST RECOMMENDATIONS (2014)**

6. The Ontario Provincial Police conduct reviews of every serious use-of-force incident, including those that result in death. The review process should include all uniformed members and communications staff directly involved in the response to the incident.

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## **JERMAINE ANTHONY CARBY INQUEST RECOMMENDATIONS (2016)**

12. Consider revising the process for performance reviews to:
    - a) Establish an explicit criterion that experience with people in crisis will be considered
    - b) Place a greater emphasis on de-escalation skills such as communication, empathy, proper use of force, and use of specialty teams where required and
    - c) Determine the appropriate use of information contained in Use of Force reports in assessing an officer's performance and suitability for particular job assignments.
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## **DAVID ANDREW DOUCETTE INQUEST RECOMMENDATIONS (2016)**

3. Whenever a sergeant is dispatched to a scene, to consider directing dispatchers and the sergeant to communicate, whenever circumstances permit, the estimated time of arrival.



### 13. MOBILE CRISIS INTERVENTION TEAMS

In addition to the permanent services that may be available for persons in crisis, such as hospitals and community agencies, some police services have also adopted mobile units in their efforts to assist persons in crisis. Many of the larger police services, including Durham, Halton, Hamilton, Ottawa, Peel, Toronto and York, have mobile teams consisting of police officers and mental health workers from hospitals or community agencies that respond to calls regarding persons in crisis.

For example, the Toronto Police Service uses what are known as Mobile Crisis Intervention Teams (MCITs). MCITs are collaborative partnerships between participating hospitals and the TPS. The program partners mental-health nurses and specially trained police officers to respond to 911 emergency and police dispatch calls involving individuals experiencing a mental health crisis. These teams assess the person's needs and connect them with appropriate mental health services. The team is not a "first responder" to an incident.

Due to resource issues, they have not always been available when needed. Currently in Toronto, the teams operate in 12 of the 17 police divisions, seven days a week, but not 24 hours per day. Several inquests and reports have recommended that MCITs should be available and used across the city of Toronto 24 hours a day.

Hamilton has adopted a different approach. The Crisis Outreach and Support Team (COAST) is a program of St. Joseph's Healthcare, comprised of child and youth crisis workers, mental health workers, nurses, social workers and plain-clothes police officers. Mental health workers respond to calls on the COAST crisis line and make preliminary assessments regarding the mental health concern. The worker determines whether to respond with telephone support or a mobile visit. The COAST mobile team, consisting of a mental health worker and a police officer is

available to respond to mental health crisis calls between 8 a.m. and 1 a.m. seven days a week.

The goal is to help the individual/family deal with the crisis in an environment where a management plan is developed to defuse the situation. Follow-up plans and supports are also offered to the person in crisis.

Over the years, different inquests have recommended the expanded use of, and resources devoted to, these types of programs.

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### **OTTO VASS INQUEST RECOMMENDATIONS (2006)**

10. The Toronto Police Service and Toronto Police Services Board should consider studying the concept of rotating “front-line” police officers through the special Mobile Crisis Teams in order to provide first-hand experience to as many officers as possible.

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### **O'BRIEN CHRISTOPHER-REID INQUEST RECOMMENDATIONS (2007)**

4. All members of the Toronto Police Service should be informed of the nature and availability of the Mobile Crisis Intervention Teams and of the importance of utilizing them in appropriate circumstances.
5. There should be further study of the possibility of utilizing Mobile Crisis Intervention Teams for phone consultation in the course of making a situation safe.
10. The Ministry of Health and Long Term Care consider promoting and providing financial support to police services and hospitals to support the expansion of operating hours of the Mobile Crisis Intervention Teams in the City of Toronto.



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### **EVAN THOMAS JONES INQUEST RECOMMENDATIONS (2012)**

16. To enhance delivery of mobile crisis intervention for persons with mental illness, explore the feasibility of the expansion of COAST or programs similar to COAST across the province where police and mental health professionals are paired and follow-up care is provided where required.

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### **ARON JAMES FIRMAN INQUEST RECOMMENDATIONS (2013)**

21. Analyze the Crisis Outreach Assessment and Support Team (COAST) program and other pilot projects currently underway, with a view to expanding those programs to communities where they would enhance response and support to individuals with mental health challenges.

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### **JARDINE-DOUGLAS, KLINGAITIS, ELIGON INQUEST RECOMMENDATIONS (2014)**

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 a.m. – 9 p.m. hours.
  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.
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### **IACOBUCCI REPORT (2014)**

43. The TPS develop a pilot Crisis Intervention Team (CIT) program, intended to complement the MCIT program, along the lines of the Memphis/Hamilton model, in the aim of being able to provide a specialized, trained response to people in crisis 24 hours per day.
44. The TPS fully implement the 10 core elements of the Memphis/Hamilton CIT model comprehensively discussed in this Report.
45. The TPS should study the effectiveness of CIT officers who participate in its pilot program by analyzing, among other things:
  - a) Whether a greater proportion of calls involving a person in crisis are addressed by a specialized response
  - b) Whether CIT officers use various forms of force less frequently than non-CIT officers
  - c) Whether CIT officers feel more capable and confident in interacting with people in crisis than non-CIT officers
  - d) Whether the relevant community notes a difference in the way they are treated by CIT officers versus non-CIT officers
  - e) Whether the proportion of persons entering the criminal justice system who suffer from mental illness declines
  - f) Any other metrics deemed relevant.

46. The TPS should amend its procedures and training to enable, where appropriate, a CIT officer to take charge of a call when a person in crisis may be involved, regardless of whether they are the first officer to arrive.
47. The TPS establish a six-month probation period for MCIT officers, which culminates in a review, to ensure that the best-suited people are in these roles. Those who successfully complete probation should be subject to a minimum commitment of two years as part of the MCIT.
48. The TPS expand the availability of MCIT to provide at least one MCIT unit per operational division. The following matters related to expanding MCIT should be addressed, in cooperation with applicable Local Health Integration Networks and partner hospitals:
  - a) Hours: Whether MCIT service should be provided 24 hours per day
  - b) First Response: Whether MCIT can act as a first response in certain circumstances
  - c) Alcohol and Drugs: Whether MCIT can respond to calls involving alcohol or drug abuse.
49. The TPS require all coach officers and supervisory officers to attend the training course designed for MCIT officers so that they gain greater awareness of mental health issues and the role of specialized crisis response.
50. The TPS establish a system of awards and recognition within TPS for exemplary MCIT service as part of the overall system of recognition and awards identified in Recommendation 30.
51. The TPS encourage supervisory officers, coach officers, and others with leadership roles to promote awareness of the role of the MCIT program within the TPS so that all front line officers know the resources at their disposal in helping a person in crisis.

52. The TPS, as part of training at the platoon level, include sessions in which MCIT units educate other officers on the role of the MCIT unit and best practices for interacting with people in crisis.
53. The TPS consider whether to amend Procedure 06-04 “Emotionally Disturbed Persons” to identify exceptions to TPS requirements such as handcuffing, the use of in-car cameras, and other measures, in recognition that the apprehension of a person in crisis under the Mental Health Act differs from other types of police apprehensions.
54. The TPS solicit the input of MCIT members to learn from their first-hand experience, with respect to any proposed changes to the MCIT program.



## 14. MENTAL HEALTH OF POLICE PERSONNEL

The psychological well-being and mental health of police officers is an important part of understanding how the police respond to people in crisis. It must be recognized that policing is difficult and stressful work. Police officers are often exposed to traumatic situations and can suffer as a result. Stress, anxiety, trauma, post-traumatic stress disorder and suicide are an all too frequent reality in the lives of police officers.

It would appear from my early discussions with the policing community, mental health workers and affected families that much more must be done to tend to the psychological well-being of officers. That is an important goal in and of itself, but it is also critical to improve the interactions between police and persons in crisis. An officer whose psychological well-being is compromised may be less able to properly assist civilians in crisis. This creates a greater likelihood of escalation and fatal outcomes. Thus, immediate attention to this issue is necessary in order to ensure that first responders are being adequately supported in their work and that if they are suffering from mental health concerns, that society is doing what is necessary to assist and treat them. The mental health and well-being of first responders, including the police, is of sufficient importance that I am planning to undertake a separate systemic review of this issue.

For the purposes of this interim report, the need to address the mental health of police officers in order to reduce instances of police use of force has already been commented on by several coroner's inquests and, most forcefully, by Justice Iacobucci.

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### **JASON EARL STEACY INQUEST RECOMMENDATIONS (2008)**

7. That a review of counseling services available to O.P.P. officers be conducted to ensure short-term and long-term support is available following incidents where an officer's direct or indirect involvement in the use of lethal force results in the death or disability of another person. Persons of expertise may wish to consider the inclusion of an officer mentoring opportunity for those who have experienced a traumatic event.

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### **TREVOR COLIN GRAHAM INQUEST RECOMMENDATIONS (2009)**

5. That police services be directed to implement mandatory psychological assessments for officers involved in traumatic events and to offer appropriate support services.

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### **GINO PETRALIA INQUEST RECOMMENDATIONS (2011)**

1. Review the contents and manner of implementation of the Durham Region Critical Incident Stress Support Team Directive (DRCISST), to ensure that it incorporates and maintains best practices in the provision, delivery and follow up in the care of critical incident stress for all officers involved in critical incidents.

Critical Incident Stress Support includes members both directly and indirectly involved in a Critical Incident, requiring mandatory attendance but voluntary participation in an Information Session and a Defusing Session (i.e. non-technical) directly following a Critical Incident. The Critical Incident Stress Support Team to provide mandatory handouts that answer FAQs and explain what to expect after a Critical Incident. (E.g. Similar to package that is available to

Metropolitan Toronto Police Services' members through Health & Safety.)

Critical Incident Stress Support should include one mandatory follow up by DRCISST to assure members have received access to appropriate resources.

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### **IACOBUCCI REPORT (2014)**

33. The TPS create a formal statement on psychological wellness for TPS members. This statement should:
- a) Acknowledge the stresses and mental health risks that members face in the course of the performance of their duties
  - b) Confirm the Service's commitment to providing support for members' psychological wellness
  - c) Emphasize the importance of members attending to their mental health needs
  - d) Emphasize the importance of members monitoring the mental health of their colleagues, and assisting colleagues to address mental health concerns
  - e) Emphasize the role of supervisory officers in monitoring the mental health of those under their command, and in intervening to assist where appropriate
  - f) Set out the psychological wellness resources available to members of the Service
  - g) Be accessible online and used in training at all levels of the Service.
34. The TPS consider whether to establish a comprehensive psychological health and safety management system for the Service.
35. The TPS provide a mandatory annual wellness visit with a TPS psychologist for all officers within their first two years of service.

36. The TPS consider providing less frequent periodic mandatory wellness visits with a TPS psychologist or other counsellor for all police officers, or, if it is not immediately possible to provide wellness visits to all officers, for any officer who works as a first responder, coach officer, or supervisory officer. The TPS should also encourage all officers to seek counseling voluntarily.
37. The TPS promote a greater understanding of the role and availability of the TPS psychologists, the EFAP and peer support groups as confidential resources that officers are encouraged to make use of to help them stay mentally healthy.
38. The TPS consider whether it would be helpful to establish an Internal Support Network for people who have experienced a shooting or other traumatic incident, or more generally to help officers with work related psychological stresses.
39. The TPS consider creating a new procedure, substantially modelled after Procedure 08-05 “Substance Abuse,” to address members’ mental health, and specifically to require officers in supervisory roles to monitor for mental health concerns of TPS members under their command, in order to identify means of providing help for mental health issues before a fitness for duty issue arises.
40. The TPS provide officers in supervisory roles with training specific to monitoring other officers’ psychological wellness and guiding preventive intervention where it is warranted.





## 15. IMPLEMENTATION OF RECOMMENDATIONS AND FUNDING

Numerous coroner's inquests have tried to ensure that their recommendations are implemented, either through deadlines for parties to report back and/or through requests for additional funding for important programs or organizations.

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### EDMOND WAI-KONG YU INQUEST RECOMMENDATIONS (1999)

1. The Ministry of Health should provide continued funding for research into the cause and treatment of schizophrenia including research into non-medical and non-drug alternatives.
2. As part of the "Making It Happen" draft, the Ministry of Health should proceed with these initiatives and be encouraged to ensure that ethno-specific psychiatric services and community-based non-medical outreach programs are funded. We would encourage these communities to present their needs to the Ministry of Health.
3. The Ministry of Health should provide a long-term funding commitment, and appoint a long-term position, to the Mental Health Law Education Project. Its mandate should be extended to provide education to members of the public, in addition to mental health care professionals. The project should include a public relations campaign to inform consumers and their families of mental health services regarding the operations of the Mental Health Act and other mental health legislation. Particular attention should be paid to consent and capacity legislation and leave of absence provisions.

8. The Ministries of Health and Community and Social Services should continue funding for the purchase and construction of new housing for consumer survivors in Toronto. Such housing should include short-term “safe-house” facilities such as the Gerstein Centre.
14. The Toronto City Council provide adequate funding to allow the Toronto Police Service Board and the Toronto Police Service to implement the recommendations of this Coroner’s jury.
23. That the Office of the Chief Coroner, on or about the anniversary date of this Inquest, April 16th, 2000, will discover and make public the progress of the implementation of the recommendations made by this jury.

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### **WAYNE RICK WILLIAMS INQUEST RECOMMENDATIONS (2000)**

10. Health Canada should appoint a coordinator to monitor the amount of dollars dedicated annually to research into the causation and treatment of schizophrenia, it being recognized that significant research funding flows from federal funding sources.

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### **PETER LAMONDAY INQUEST RECOMMENDATIONS (2005)**

14. The National Research Council and the Ontario Provincial Government should consider funding for continued research into sudden, unexpected death during police custody.

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### **JASON EARL STEACY INQUEST RECOMMENDATIONS (2008)**

8. That the Ministry examines any existing studies regarding how civilians react when confronted with the “police challenge” in a variety of circumstances, to ensure that current protocols are optimized. If existing studies are not considered relevant or adequate for situations that the police in Ontario are likely to encounter, then the Ministry should consider commissioning and funding such a study.

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### **JERRY KNIGHT INQUEST RECOMMENDATIONS (2008)**

15. Encourage funding for continued research into sudden death that may occur in police custody.

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### **BYRON RICHARD DEBASSIGE INQUEST RECOMMENDATIONS (2010)**

4. The Ministry of Health and Long-Term Care should make funds available for the creation of additional teams which provide comprehensive community-based psychiatric treatment and support; commonly referred to as Assertive Community Treatment (ACT) teams to serve mentally disordered persons in the community.

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### **SEAN REILLY INQUEST RECOMMENDATIONS (2011)**

11. To encourage funding for continued research into sudden deaths that occur in police custody.

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## **JARDINE-DOUGLAS, KLIBINGAITIS, ELIGON INQUEST RECOMMENDATIONS (2014)**

64. Increase funding and availability for more Mental Health case workers.
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.
74. Provide further funding to expand community resources with mental health crisis support. For example, the Gerstein Centre, COTA, etc.
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## **IACOBUCCI REPORT (2014)**

75. The Chief of Police strike an advisory committee, to advise the chief of police on how best to implement the recommendations contained in this Report. In this regard, I recommend:
- a) Stakeholder Membership: The advisory committee should include leading members of key stakeholder groups, including hospitals, community mental health organizations, the police and those with lived experience of mental illness
  - b) Limited Membership: The advisory committee should be of manageable size – large enough to provide adequate representation of stakeholder groups, but small enough to be efficient
  - c) Advisory Role: The advisory committee should play only an advisory role and should not have decision-making authority, unless the chief of police determines otherwise
  - d) Defined Role: The role of advisory committee members should be defined in clear terms at the time of the creation of the advisory committee, so that there is no misunderstanding as to their function and authority

- e) In Camera Meetings: The discussions of the advisory committee should be held in camera in order to promote candour and collegiality, unless otherwise directed by the chief of police. Advisory committee members should agree as a condition of membership that they will not disclose the committee's discussions
  - f) Communications with the Public: The advisory committee and its individual members should not advocate publicly or use the media as a vehicle for seeking to persuade the chief of police (or the TPS more broadly) to make specific decisions, or to criticize the TPS. The advisory committee should not be a political body but rather a true advisory body, with the effectiveness of its advice deriving from the quality of its membership
  - g) Staffing: The advisory committee should be provided with reasonable assistance by staff as needed, whether using existing TPS personnel or otherwise
  - h) Annual Reports: The advisory committee should prepare annual reports for the chief of police, summarizing the state of progress in implementation, any significant divergences between the advice of the committee and the decisions taken by the TPS in the past year, and major recommendations going forward relating to implementation, prioritization, scheduling, planning, resource allocation, public reporting and related topics.
76. In order to ensure transparency and accountability during the implementation stage, the TPS issue a public report at least annually after the date of release of this Report, with the following contents:
- a) A list of recommendations implemented in whole or in part to the date of the report, with an explanation of what was done and when
  - b) A list of those recommendations still to be implemented, with an indication of the anticipated timing of implementation
  - c) If applicable, a description of resource constraints that affect the ability of the TPS to implement any recommendations, or the timing of implementation

- d) If applicable, a description of any other limitations on the ability of the TPS to implement any recommendations (such as lack of cooperation from other organizations, change in circumstances, etc.)
  - e) If applicable, a list of recommendations that the TPS decided not to implement at all, and an explanation of the reasons for decision
  - f) If applicable, a list of recommendations that the TPS decided to implement in modified form (different from what was recommended in this Report), and an explanation of the reasons for decision
  - g) A discussion of any significant divergences between the advice of the advisory committee and decisions made by the TPS.
77. The chief of police and the executive management team of the TPS play a significant leadership role in requiring implementation of the recommendations in this Report, and in encouraging (through leadership by example and otherwise) voluntary compliance.
78. The TPS appoint a senior officer to assume overall operational responsibility and executive accountability for the implementation of the recommendations in this Report, subject to the direction of the chief of police or the chief's designate.
79. The TPS create an implementation team, led by the senior officer identified above and composed of those TPS members charged with responsibility to implement recommendations within specified areas of the Service (e.g., within the MCIT program, within Psychological Services, within the Toronto Police College, etc.).
80. The chief of police or his delegate appoint, within each TPS division and unit, at least one TPS member formally charged with responsibility for ensuring effective implementation of the recommendations in this Report at the division or unit level.
81. In connection with those recommendations above that call for further study, examination and analysis of specific issues:

- a) Stakeholder Input: Where appropriate, the TPS seek to involve representatives of affected stakeholders meaningfully in the work
- b) Deliverables: The TPS identify specific deliverables sought from those tasked with the work, and a timeframe for delivery
- c) Reporting Requirement: There be a regular reporting requirement for any work taking place over an extended period, whereby the senior TPS officer in charge of implementation is kept informed regarding the progress of the work.

82. In connection with those recommendations above that call for the TPS to work with outside organizations such as government ministries, hospitals and others, the TPS take a leadership role in forging and fostering the necessary relationships.

83. The TPS collaborate with academic researchers, hospitals and others to evaluate the effectiveness of TPS initiatives undertaken as a result of this Review, including, where applicable, both quantitative and qualitative evaluations.

84. A follow-up review be conducted—whether by TPS personnel, by an independent review body or by committee of interested stakeholders—in five years' time to assess the degree of success achieved in minimizing the use of lethal force in encounters between the TPS and people in crisis, and to make further recommendations for improvement. I recommend that the results of that review be made public, and that the reviewers be similarly tasked with developing recommendations for implementation.

3.

# THE WORK TO BE DONE IN THE MONTHS AHEAD





As I reflected earlier, this systemic review will now focus more intently on the extent to which recommendations made by previous inquests and Justice Iacobucci have been adopted and implemented by police services across Ontario. The goal is not only to document what implementation has or has not taken place, but to identify best practices in policing.

The need for an audit focused on implementation and best practices is timely. Justice Iacobucci recommended that a report be produced one year from the date of his report setting out what steps had been taken by the TPS towards implementation. On September 16, 2015, the TPS reported to the Toronto Police Services Board that it had implemented 79 of Justice Iacobucci's 84 recommendations.<sup>15</sup> The TPS also reported that it has implemented 45 of the 46 Jardine-Douglas, Klibingaitis, Eligon Inquest recommendations that were assigned to the TPS (28 recommendations were said to be assigned to other organizations).

However, on November 25, 2015, the former chair of the Toronto Police Services Board, Alok Mukharjee, questioned whether the recommendations that the TPS claimed to have implemented had, in fact, been implemented.<sup>16</sup>

Similarly, in January 2016, after Constable Forcillo was convicted of the attempted murder of Sammy Yatim, counsel for Mr. Yatim's mother also cast doubt on whether the Iacobucci recommendations had truly been properly implemented.<sup>17</sup>

And in May 2016 family members of people killed by the police expressed skepticism about the utility of inquests and the implementation of coroner's jury recommendations, given that many of the same recommendations have been issued on multiple occasions and yet the same type of problems that lead to police shootings continue to arise.<sup>18</sup>

In my view, the public interest requires us to independently evaluate the nature and extent of implementation not only of Justice Iacobucci's report, but the full range of recommendations that have been made by

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15 [https://www.torontopolice.on.ca/publications/files/reports/20150911-iacobucci\\_report\\_recommendations\\_with\\_tps\\_response.pdf](https://www.torontopolice.on.ca/publications/files/reports/20150911-iacobucci_report_recommendations_with_tps_response.pdf)

16 <https://nowtoronto.com/news/ex-police-watchdog-speaks-out-on-yatim/>

17 <http://www.cbc.ca/news/canada/toronto/james-forcillo-verdict-1.3414974>

18 <https://www.thestar.com/news/gta/2016/05/15/coroners-inquest-system-is-broken-say-advocates.html>



coroner's juries. Equally important, an audit will reveal what is working well or poorly, and enable me, in consultation with experts in policing and mental health, to identify best practices and additional recommendations that need now be made.

At first instance, the OIPRD does not intend to audit every police service in the province. Instead, we will focus on the police services involved in the deaths that generated the coroner's inquests examined in this interim report. We will conduct a comparative analysis of what is being done by police services to address people in crisis, and the differing policing experiences throughout Ontario.

Our systemic review will work in conjunction with an advisory group consisting of members from the justice, mental health and academic fields who have agreed to participate. Once the initial work is mostly complete, the advisory group will, among other things, generate a discussion paper on best practices and questions that will form the basis for a symposium sponsored by the OIPRD, where experts in policing and mental health and other stakeholders will make presentations and consider the issues identified in the discussion paper. Ultimately, these and other approaches will enable me to issue a final report.

My hope is that this interim report, and ultimately the final report, will contribute to a better understanding of the issues that impact the relationship between the police and the civilians they serve. As reflected at the outset of this work, much work has been done already to study and understand police interactions with people in crisis. I am grateful to those who have examined this issue before me. They have provided me with a critical foundation for the work to be done in the months ahead. I hope that the auditing we will be doing will help us understand to what extent prior recommendations have been implemented and where we can continue to make changes to improve.

As I wrote at the outset of this report, even one death of a civilian as a result of an interaction with the police is one too many. Our goal must be zero deaths. To achieve that goal requires two things: the will to make the necessary changes and a cooperative and collaborative approach among the healthcare system, community-based agencies serving clients with mental health issues and police services. All must do their part to ensure better outcomes in police interactions with people in crisis. I hope that in the months ahead, we can demonstrate our collective will and the cooperation required to ensure that we achieve this goal.

As always, I welcome submissions or input from any affected party or stakeholder as our work progresses.

# GLOSSARY OF ACRONYMS AND TERMS

**ACT:** Assertive Community Treatment

**AED:** Automatic External Defibrillator

**CAD:** Computer-aided Dispatch is a communications technology that is part of police records management systems.

**CEW:** Conducted Energy Weapon

**CIT:** Crisis Intervention Team

**COAST:** Crisis Outreach Assessment and Support Team

**C.O. Bick College:** Toronto Police Service training facility from 1977 to 2009. It has been replaced by the new Toronto Police College.

**Community Treatment Order:** A Community Treatment Order is a doctor's order for a person to receive treatment or care and supervision in the community. The Mental Health Act sets out certain criteria that must be met before a doctor will issue or renew a Community Treatment Order.

**ConnexOntario:** Organization funded by the Ontario government that provides free and confidential health services information for people experiencing problems with alcohol and drugs, mental illness or gambling.

**Cota:** A community-based organization that supports adults with mental health and cognitive challenges to live well within their communities.

**CPIC:** The Canadian Police Information Centre is the central police database where Canadian law enforcement agencies can access information on crimes and criminals.

**CPR:** Cardiopulmonary resuscitation

**DRCISST:** Durham Regional Critical Incident Stress Support Team Directive

**EDP:** Emotionally Disturbed Person

**EFAP:** Employee and Family Assistance Program

**Empowerment Council:** An independent, incorporated organization that is a voice for clients and ex-clients of mental health and addiction services.

**EMS:** Emergency Medical Services

**ETF:** Emergency Task Force

**Form 1:** Application for Psychiatric Assessment. The Mental Health Act gives every physician in Ontario the right to sign an Application for Psychiatric Assessment.

**Gerstein Centre:** A community-based mental health crisis service in the Toronto area.

**Hog-tie:** Hands cuffed behind the back, ankles cuffed and hands and ankles linked with another set of handcuffs.

**ICCS:** In-car Camera System

**LHIN:** Local Health Integration Network

**MCIT:** Mobile Crisis Intervention Team

**MCSCS:** Ministry of Community Safety and Correctional Services

**Memphis:** A first-responder crisis intervention team model of police-based crisis intervention with community, mental health care and advocacy partnerships first developed in Memphis U.S.

**MOHLTC:** Ministry of Health and Long-Term Care

**NICHE:** Police records management system used by the majority of police services in Ontario.

**OACP:** Ontario Association of Chiefs of Police

**OPP:** Ontario Provincial Police

**PRU:** Primary Response Unit

**SIU:** Special Investigations Unit

**SIP:** The Special Interest Police repository of CPIC is a database where police may, in various circumstances, enter information regarding an individual, including mental health information.

**Taser:** Taser International is the only conducted energy weapon company approved by the Ontario Ministry of Community Safety and Correctional Services for use by police officers in Ontario. Police services are only permitted to use two models: the TASER M26 or the TASER X26. The TASER X26 has an optional audio/visual attachment to record the use of the CEW from the moment it is activated until it is turned off.

**TPC:** Toronto Police College

**TPS:** Toronto Police Service

**TPSB:** Toronto Police Services Board

**TTC:** Toronto Transit Commission

**Use of Force Report:** Under the Police Services Act Regulation 926, section 14.5 (1) and (1.1), a member of a police force shall submit a report whenever the member draws a handgun in the presence of a member of the public, excluding a member of the police force who is on duty, points a firearm at a person or discharges a firearm; uses a weapon other than a firearm on another person; or uses physical force on another person that results in an injury requiring medical attention. The member is required to submit the report to the chief of police or Commissioner if the member is an Ontario police officer as defined in the Interprovincial Policing Act, 2009. The Use of Force Report Form from the PSA regulation 926 is reproduced here:

(Check more than one box in each section, where appropriate)		Police Service		Location Code (if applicable)	
<b>Part A</b>					
Date (day/month/year)		Time Incident Commenced (24 hr)		Time Incident Terminated (24 hr)	
<input type="checkbox"/> Individual Report	Length Of Service (years completed)	Rank	<input type="checkbox"/> Team Report	Type of Team	# of Police Officers Involved
<b>Type Of Assignment</b> <input type="checkbox"/> General Patrol <input type="checkbox"/> Foot Patrol <input type="checkbox"/> Traffic <input type="checkbox"/> Investigation <input type="checkbox"/> Drugs <input type="checkbox"/> Off-duty <input type="checkbox"/> Other (specify)		<b>Type Of Incident</b> <input type="checkbox"/> Robbery <input type="checkbox"/> Break and Enter <input type="checkbox"/> Domestic Disturbance <input type="checkbox"/> Other Disturbance <input type="checkbox"/> Traffic <input type="checkbox"/> Suspicious Person <input type="checkbox"/> Serious Injury <input type="checkbox"/> Homicide <input type="checkbox"/> Weapons Call <input type="checkbox"/> Alarm <input type="checkbox"/> Other (specify)		<b>Police Presence At Time Of Incident</b> <input type="checkbox"/> Alone <input type="checkbox"/> Police Assisted (specify #) _____ <b>Attire</b> <input type="checkbox"/> Uniform <input type="checkbox"/> Civilian Clothes <b>Number of Subject(s) Involved in Incident</b> <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Other (specify #) _____	
<b>Type Of Force Used</b> <small>(Includes all options used during incident &amp; rank in sequence of use)</small> Firearm - discharged _____ Firearm - pointed at person _____ Handgun - drawn _____ Aerosol Weapon _____ Impact Weapon - Hard _____ Impact Weapon - Soft _____ Empty Hand Techniques - Hard _____ Empty Hand Techniques - Soft _____ Other (specify) _____		<b>Was Force Effective?</b> Yes No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<b>Reason For Use Of Force</b> <input type="checkbox"/> Protect Self <input type="checkbox"/> Protect Public <input type="checkbox"/> Effect Arrest <input type="checkbox"/> Prevent Commission of Offence <input type="checkbox"/> Prevent Escape <input type="checkbox"/> Accidental <input type="checkbox"/> Destroy an Animal <input type="checkbox"/> Other (specify)	
		<b>Alternative Strategies Used (if Applicable)</b> <input type="checkbox"/> Verbal Interaction <input type="checkbox"/> Cover <input type="checkbox"/> Concealment <input type="checkbox"/> Other (specify)			
		<b>Type Of Firearm Used (if Applicable)</b> <input type="checkbox"/> Revolver <input type="checkbox"/> Semi-automatic <input type="checkbox"/> Rifle <input type="checkbox"/> Shotgun <input type="checkbox"/> Other (specify)		<b>No. Of Rounds Discharged (if Applicable)</b> _____	
<b>Distance</b> <small>(Between you &amp; subject at the time the decision was made to use force)</small> <input type="checkbox"/> Less than 2 metres <input type="checkbox"/> 2 to 3 metres <input type="checkbox"/> 3 to 5 metres <input type="checkbox"/> 5 to 7 metres <input type="checkbox"/> 7 to 10 metres <input type="checkbox"/> Greater than 10 metres		<b>Weapons Carried By Subject(s)</b> 1 2 3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unknown <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> None <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Revolver <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Semi-automatic <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rifle <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shotgun <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knife/Edged Weapon <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Baseball Bat/Club <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (specify)		<b>Location Of Subject's Weapon</b> <small>(At time decision was made to use force)</small> 1 2 3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> In-hand <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> At hand <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Concealed on person <b>Total Number:</b> _____	
<b>Location Of Incident</b> <b>Outdoors</b> <input type="checkbox"/> Roadway <input type="checkbox"/> Laneway <input type="checkbox"/> Yard <input type="checkbox"/> Park <input type="checkbox"/> Rural <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Other (specify)		<b>Indoors</b> <b>Private Property</b> <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Hallway <b>Public Property</b> <input type="checkbox"/> Financial Institution <input type="checkbox"/> Commercial Site <input type="checkbox"/> Public Institution <input type="checkbox"/> Other (specify)		<b>Weather Conditions</b> <input type="checkbox"/> Clear <input type="checkbox"/> Sunny <input type="checkbox"/> Cloudy <input type="checkbox"/> Rain <input type="checkbox"/> Snow/sleet <input type="checkbox"/> Fog <input type="checkbox"/> Other (specify)	
		<b>Lighting Conditions</b> <input type="checkbox"/> Daylight <input type="checkbox"/> Dusk <input type="checkbox"/> Dark <input type="checkbox"/> Good Artificial Light <input type="checkbox"/> Poor Artificial Light <input type="checkbox"/> Other (specify)			
<b>Person Injured</b> 1. Self 2. Other Police Officer 3. Subject 4. Third Party		<b>Medical Attention Required</b> Yes No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<b>Nature Of Injuries</b> Minor Serious Fatal Unknown <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Narrative: (if no occurrence report) - Do not include personal names or information.					
If more space is required please continue on back of form.					
Reviewed by Supervisor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reviewed by Training Analyst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recommended Post Traumatic Incident Counselling	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Recommended Other Training	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date (day/month/year)					
<b>Part B</b>					
Officer Involved (name, rank & badge #)					
Date of last use of force refresher training					
Would you like to participate in an interview with a training sergeant/analyst to discuss this incident and/or use of force training? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Additional training recommended by: <input type="checkbox"/> training analyst <input type="checkbox"/> supervisor					
Type of training recommended:					





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