Office of the
Chief Coroner
Bureau du
coroner en chef

# Verdict of Coroner's Jury
# Verdict du jury du coroner

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

We the undersigned / Nous soussignés,

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

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

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

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

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

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

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

Name of Deceased / Nom du défunt
Michael Eligon

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

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

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

By what means / Circonstances du décès
Homicide

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

_____

_____

_____

_____
Original signed by jurors / Original signé par les jurés

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

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

_____
Coroner's Signature / Signature du coroner

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Office of the
Chief Coroner
Bureau du
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**Verdict of Coroner's Jury**
**Verdict du jury du coroner**

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

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

***Reyal Jardine-Douglas, Sylvia Klibingaitis, Michael Eligon***

**JURY RECOMMENDATIONS**
**RECOMMANDATIONS DU JURY**

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

**KEY**

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

# POLICE-RELATED

## RESEARCH & ANALYSIS

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

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

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

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

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_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

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

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

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

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

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

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

Name of Deceased / Nom du défunt
Reyal Jardine-Douglas

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

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

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

By what means / Circonstances du décès
Homicide

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

_____

_____

_____

_____
Original signed by jurors / Original signé par les jurés

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

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

_____
Coroner's Signature / Signature du coroner

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_____ of / de Toronto, Ontario

_____ of / de Toronto, Ontario

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

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

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

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

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

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

Name of Deceased / Nom du défunt
Sylvia Klibingaitis

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

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

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

By what means / Circonstances du décès
Homicide

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

_____
_____
_____
_____
Original signed by jurors / Original signé par les jurés

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

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

_____
Coroner's Signature / Signature du coroner

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

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

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

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

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

## TRAINING & DEVELOPMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Recommendations to Ontario Police College and Toronto Police College:**

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

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

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

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

**Recommendations to the Toronto Police Service:**

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

## EQUIPMENT/TOOLS/SYSTEMS

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

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

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

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

**Recommendations to the Toronto Police Service:**

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

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

## MOBILE CRISIS INTERVENTION TEAM (MCIT)

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

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

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

**Recommendation to the Toronto Police Service:**

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

## POLICY/PROCESS

**Recommendations to the Toronto Police Service:**

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

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

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

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

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

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

**Recommendation to Toronto Police Service & Empowerment Council:**

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

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**Recommendation to Toronto Police Service:**

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

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

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

**Recommendations to Toronto Police Service Corporate Planning:**

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

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

## COMMITTEE/CONSULTATION

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

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

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

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

## PUBLIC EDUCATION/COMMUNITY RELATIONS

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

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

**Recommendations to Toronto Police Service:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Recommendations to the Ontario Hospital Association:**

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

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

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

**Recommendation to the Ontario Medical Association:**

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

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

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

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

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

# COMMUNITY RELATIONS & PUBLIC EDUCATION

**Recommendations to the Ministry of Health and Long Term Care:**

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

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

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**Recommendations to the Office of the Chief Coroner:**

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

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

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

-End-

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