Release date: October 30, 2006

THE FATALITY INQUIRIES ACT

REPORT BY PROVINCIAL JUDGE ON INQUEST

Respecting the death of: **PETER STEVENSON**

An inquest respecting the said death having been held by me between June 26, 2006 and July 7, 2006, at the Town of The Pas, in Manitoba, I hereby report as follows:

The name of the deceased is **PETER STEVENSON**.

The deceased came to his death on the 2nd day of September, 2004, at approximately 7:28 p.m. at the Town of The Pas, in the Province of Manitoba.

The deceased came to his death by the following means:
Sudden Cardiac Arrest consistent with agitated delirium.

Dated at the Town of The Pas, in Manitoba, this 25 day of October, 2006.

Roger Gregoire

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ROGER J. C. GREGOIRE,
PROVINCIAL JUDGE

Copies to:
Ms. Breta Passler, counsel for Inquest
Mr. Dean B. Head, counsel for Family
Mr. Mark G. Mason, counsel for R.C.M.P.
Mr. Michael T. Green, counsel for Norman Regional Health Authority
Mr. Tyler J. Kochanski, counsel for Dr. Medd
Ms. Sandra Hoeppner, counsel for Department of Family Services and Housing
Chief Medical Examiner, Dr. Balachandra
Minister of Justice, The Honourable Dave Chomiak
Minister of Health, The Honourable Theresa Oswald
Minister of Family Services & Housing, The Honourable Gord Mackintosh
Chief Judge of the Provincial Court of MB, The Honourable Raymond Wyant

Peter Stevenson initially went to The Pas Health Complex on June 1, 2004 in order to get help with his psychiatric disorder. This was not the first time he had been there for help. He was detained as an involuntary patient pursuant to the provisions of the Mental Health Act. Unfortunately, on September 2, 2004 while on a pass from the hospital he consumed alcohol and when he returned to the ward problems ensued resulting in his being restrained. He died in the process of what the pathologist initially described as sudden cardiac arrest. A mandatory inquest was called and the evidence was heard at The Pas over 9 consecutive days between June 26, 2006 and July 7, 2006 during which time volumes of documentary evidence were tendered and the court heard from 26 witnesses. The inquest also heard the tape recorded conversation between the deceased and the receptionist at the R.C.M.P. which had occurred shortly before his death.

Background

To help understand what transpired on the evening of September 2, 2004 it is necessary to attempt to obtain a fuller understanding of Peter Stevenson's life. Mr. Stevenson was 30 years of age when he died and the court was reminded that had Peter still been alive he would have celebrated his 32nd birthday during the course of the testimony at the inquest. His childhood social worker opined that Peter would find it amusing that so many lawyers were now devoting so much time to his case. Standing had been granted to his family represented by Mr. Dean Head, the Province of Manitoba, represented by Ms. Hoeppner, Dr. Medd represented by Mr. Kochanski, the Regional Health Authority represented by Mr. Green, the RCMP represented by Mr. Mason and counsel for the inquest, Ms. Passler.

Peter's life was not an easy one. Born to parents who both had a chronic alcohol abuse problem, he came to the attention of Child and Family Services early in life and was apprehended and became a permanent ward before he was 2 years of age. Finding a stable and ongoing placement for Peter proved difficult and he experienced a series of foster placements, some of which may not have been well suited to his needs. Peter had his problems, especially with control issues, as he became an adolescent. He was also clearly intellectually challenged but to his credit he did stick it out in school and completed a modified program which earned him graduation in an occupational entrance (304) grade 12 program. It is obvious that Peter had positive attributes as well as he appeared to have been well liked by those who knew him and by those who worked upon his behalf. It was obvious by the emotional response demonstrated by many of the witnesses who testified that Peter had held a special place in their hearts.

It became obvious to his child care worker that Peter Stevenson would need help even as an adult in order to live as close to a normal life as possible. Psychological testing was carried out and it was determined that his intellectual abilities were about the equivalent of a grade 6 understanding – his I.Q. was 77. Apparently the usual cut off point for a designation of mental retardation and the government support that flows from such a designation is an I.Q. below 70. When he was 20 years old Peter was also seen by a geneticist, Dr. Chudley, who concurred in the diagnosis that Peter suffered from Fetal Alcohol Syndrome. Dr. Chudley expressed the following opinion: "Peter is going to need close monitoring and a lot of encouragement to keep him on track and off alcohol and improvement in his self esteem."

After outlining some of Peter's issues he concluded by describing Peter as an unfortunate young man.

Because of this information, proper discretion was exercised and Peter did receive some assistance from the Department of Family Services and Housing, Supported Living Program, Services for Persons with Disabilities Division. Despite their best efforts, housing for Peter proved to be extremely challenging to say the least. Peter was easily sucked in by so called friends who acted almost as leeches whenever Peter received money. When Peter had money the alcohol flowed at his places of accommodation, there were damages to the apartments, complaints from other tenants, threats to landlords, and the like. Soon this made Peter a *persona non grata* and his reputation in The Pas and Flin Flon made it next to impossible for him to obtain regular housing.

Peter lived for a short while at the Norman Community Centre house in Flin Flon but the other residents were a lot less independent and, in fact, more intellectually challenged than Peter. His independent lifestyle, which included going to bars, drinking and being less subject to control, was seen as detrimental to the other residents; he just didn't fit in and so he couldn't continue to reside there. The only other group home in The Pas was for adults who were even more developmentally challenged. Favours were called in and as a result, Peter stayed for a time at the Flin Flon Indian and Métis Friendship Centre. But Peter would leave for periods of time and come back to The Pas. In the time frame before his last admission to hospital in The Pas efforts were made by Walter Mink, his direct service worker, to obtain housing at the Opasquia Cree Nation, as Peter was a member, but these

efforts also proved fruitless, partly because Peter wouldn't keep appointments. His housing situation as described by Walter Mink, his direct services worker, who was supposed to have 15 contact hours per week in the year 2006, can only be described as pathetic. Peter was described as staying at whatever place he could find from night to night with relatives or acquaintances. One such location was a shack at Watchi Bay where he slept with dogs, without a shower or bath facilities and from which he smelled heavily of dog urine. This same worker clearly described what can only be described as Peter suffering from delusions and hallucinations and clearly in a psychotic state. This worker had received in his estimation inadequate training to be able to deal with the problems which Peter now demonstrated but yet he stated that he continued his contact with Peter out of a sense of devotion to someone who was apparently a relative.

Community Mental Health also had involvement with Mr. Stevenson who by now had had residential treatment in Brandon, Selkirk and The Pas psychiatric facilities. One such stay at Selkirk was for as long as 7 months. By the time of Peter's final admission at The Pas he had been diagnosed as a person who suffered from paranoid schizophrenia; in fact treatment had been tried with a number of the usual anti-psychotic medications with varying degrees of success. In the opinion of Dr. Medd, his psychiatrist, there was a necessity to attempt treatment with clozapine, a much more effective but also a potentially dangerous drug. Careful titration and monitoring for possible life threatening side effects were necessary and hence the reason for the rather lengthy involuntary stay of Mr. Stevenson on his last admission to The Pas Hospital.

There appears to have been a paucity of sharing of the medical information concerning Peter's psychiatric condition with those who worked for the supported living program and they were mainly unaware of the seriousness of Peter's condition.

With the help of the supported living program Peter Stevenson was able to contribute to society through his subsidized employment at the recycling centre. He apparently enjoyed working there and this was to continue to be an important part of the plan both by mental health and supported living.

As can be anticipated, Peter also had his involvement with the local R.C.M.P. both as an accused and a victim. Some of his encounters with the law involved acts of violence, such as an assault conviction involving his sister. There were also sexual assault accusations made by Peter that could not be proven and two of which the police thought to be unfounded. Were these the product of a delusion caused by his schizophrenia or was he unable to provide sufficient details as to time and date due to his F.A.S.? Although this question will remain unanswered we do know that Peter was very much troubled by what he clearly believed to have been a sexual assault perpetrated against him by a male person. Peter had also spent two nights at the R.C.M.P. cells during the month of August, 2004, because he had been drinking. This was during the period of his involuntary admission to the hospital. It appears to be the case that the R.C.M.P. are regularly called to the hospital to pick up and detain violent psychiatric patients who are then placed in the R.C.M.P cells. This had been the plan once again on September 2, 2004, the day that Peter Stevenson died.

September 2, 2004

On September 2, 2004, Mr. Stevenson awakened at the psychiatric ward of The Pas Health Complex. The ward can accommodate up to 8 patients but the evidence indicates that only 4 patients were there at this time. There were 3 staff members who were on shift and worked on the ward. Cindy Fortin is a graduate nurse from the Bachelor of Nursing program at the University of Manitoba. She was not yet registered and had but 3 weeks experience as of September 2, 2004. As part of her degree she had taken a mental health course which included 12 shifts at the Selkirk Mental Health Institution. She had also completed her senior practicum at The Pas psychiatric ward.

Erin Bukowski was a registered psychiatric nurse. She had graduated in 2003 and after completing her duties as a student nurse at The Pas through Brandon University she started working in September of 2003.

The nurses worked 12 hour shifts with different rotations and on September 2, 2004 the nurses were working from 7:30 in the morning to 7:30 in the evening.

Daniel Pommer had worked as a psychiatric nursing assistant for 3 years before September 2, 2004. Prior to this he had worked as a community proctor with the Health Care program for 6 years and held a proctor's certificate. His shift that day was 10:30 a.m. to 10:30 p.m.

The psychiatric ward is on the 4th floor of St. Anthony's Hospital and a plan drawing prepared by Cpl. Olson was filed as an exhibit. It is a locked area and you either have to be

buzzed in by the nurse or enter a numbered code on the key pad. Upon entering the ward the view is of a basically open area with a horseshoe shaped nursing station to the far left. There is a kitchen/living type area with tables and chairs and a pay phone to the right. There is also a smoking room to the far right and a seclusion room opposite the nursing station. There are two windows at the end of the tables.

Dan Pommer testified that when he came on shift Peter had already left for his job at the recycling centre.

Nurse Fortin testified that Peter was expected back around 4:30 p.m. but he didn't return and so about 5:30 p.m. a call was made to Dr. Medd, his treating psychiatrist. As it was anticipated that Peter would be discharged within about a week , it was Dr. Medd's instructions that there was no need at that time to call the R.C.M.P. in order to locate him. The next information as to Peter's whereabouts came by way of a phone call from Allan Cartwright who was requesting some of Peter's money that was kept by the nurses on the ward in an attempt to help Peter budget it. Mr. Cartwright's request was not successful and within five minutes Peter telephoned. He was told that he was late and that he had to return to the hospital. The next call came from the hospital switchboard operator who advised that Peter was downstairs at the hospital and that he wanted money. The operator was directed to have him come up to the ward. The request for the money was purportedly so that he could go to the movies with his friend. Peter then came up to the ward with his friend Allan Cartwright. Peter stayed back from the nursing desk but nurse Fortin could detect the odour of alcohol and concluded that Peter had been drinking. The nurses indicated to Peter that he

knew the rules regarding drinking and that there would be no passes for the evening. This was a discretionary decision made by the nurses but one within the bounds of the limits set by the psychiatrist. The situation continued to escalate from this point on.

Where had Peter been from 4:30 p.m. until he returned around 7:00 p.m.?
There were initially two different versions, one from his direct services worker, Walter Mink and one from Allan Cartwright.

Walter Mink was a contract employee as a direct services worker for the Department of Family Services and Housing. He commenced work in January of 2004 and Mr. Stevenson was a client of his. It was Mink's understanding that he was to provide companionship, spend time with him, provide rides for him and to make sure that his basic needs were met. Mr. Mink had no formal training, just experience, but he felt overwhelmed. He testified that: "I don't think anybody knew how Peter really was – but I didn't tell anybody, I didn't know how." His contract was for 15 hours per week but Mr. Mink felt that he spent much more time than that with Peter and candidly acknowledged that the times he noted in his DSW case notes didn't necessarily reflect what and when his actual contacts were. Mr. Mink had three separate notations for September 2, 2004.

In his DSW case notes – date/pay period September 3, 2004 he notes the following for September 2, 2004. 5 to 7 p.m. (but it does look as though he had written over what was originally written as 6 p.m. to 8 p.m.):

> "Peter took me out for coffee and bought me a hamburger. He was happy because he got a new bank card and wanted to use it."

There were also two handwritten statements made by Mr. Mink. One is dated September 16, 2004 and is headed "Report of Peter Stevenson, Thursday, September 2, 2004." The other is undated and starts, "On Thursday, September 2, 2004, I was with Peter for the last time." Both describe similar incidents; that he picked Peter up at the Kikiwak Inn; that they went to Tim Horton's for coffee, (one states 20 minutes, the other 30 minutes); that they drove to Watchi Bay to try to pick up some clothes, but nobody was there; that they stayed there for about 45 minutes; then that they drove to Big Eddy because Peter wanted to look for his jacket at a friend's house, but nobody was home. In the statement made September 16, 2004 Mr. Mink described driving around and going to Moose Park around 6:15 p.m. This is not mentioned in his undated statement (even by the time estimates mentioned therein he wouldn't have left Watchi Bay until after 6:30 p.m.); then he states they went to A & W for coffee and a hamburger that Peter bought for him with his new card, and then to the hospital at 7:00 p.m., give or take a few minutes. To drive from Big Eddy to Moose Park and back to the A & W, have a burger and coffee and drive back to The Pas Hospital in that short of a time frame, i.e. 30 minutes to 45 minutes would have to be done in a considerable hurry, if it is at all possible…

During his testimony, Mr. Mink related the same places, i.e. Tim Horton's, driving around looking for a jacket, going to the A & W and back to the hospital, but candidly stated that "I honestly don't know how long I spent with him." He concluded his testimony by saying that he cannot be sure if what he related even took place on September 2, 2004 or at an earlier date.

Mr. Mink did testify in an emotional fashion and it seems evident that he had formed a bond with Mr. Stevenson and that his death caused him sorrow. I'm also satisfied that Mr. Mink attempted to some extent to assist Peter with housing and that he observed clear symptoms of Peter's mental illness. Mr. Stevenson came back to the hospital to obtain money and first started to call for some at 6:30 p.m. Why would he do so if he had just received his brand new bank card which he had just successfully used at the A & W? Mr. Stevenson attended to the hospital at 7:00 p.m. while under the influence of alcohol and the autopsy revealed a blood alcohol level of 112 mg/dL and tested positive for cannabis use whereas Mr. Mink states that Peter did not consume alcohol or use cannabis while with him.

I have concluded that Mr. Mink's evidence as to what occurred on September 2, 2004 had to be received with a great deal of skepticism and although the events indicated may have occurred at some point in time, I conclude that it was not on September 2, 2004.

Allan Cartwright also testified as to the events of September 2, 2004. He states that he and Mr. Stevenson were very good friends. Around 4:30 p.m. he says that Peter came to his place at 462 Taylor Avenue, that they went for a walk, then to the Wescana Hotel to play pool for approximately an hour where they each had a couple of "Bud" beer.

From there they bought a 12 of beer and took a cab to Peter's mom's place; his father-in-law was there. They were there about 2 ½ hours and the 2 of them finished the beer. Peter had the money to pay for this.

Peter wanted more money to buy more beer and they checked at the taxi stand to see if Peter could borrow some but without success. Apparently it was Peter's mother who drove them uptown for this purpose. That is when they attended to the hospital and made the phone calls. He indicated that the nurse was told that the money was so that Peter could go to the movie, but he acknowledged it was really to buy more beer. Mr. Cartwright stated that he didn't know that Peter was staying at the hospital or that he was on any medication. He also testified that many of the times that they got together they would drink. Mr. Cartwright acknowledged that he went to the psychiatric ward with Peter and that when asked to leave the ward he did so. Mr. Cartwright had made a statement to the R.C.M.P. commencing at 12:16 a.m., after Peter's death. He indicated therein that they were at Peter's mom's for only 2 hours and not 2 ½ ; he doesn't mention Mrs. Stevenson driving them back to town; and he says that they had 3 beer each at the Wescana and not two. He also tells the police that the money requested was so they could go to the movies. His statement was mostly consistent with his testimony and I find his version to be the more accurate description of what took place immediately before and just after Peter returned to the hospital. I am satisfied that after 4:30 p.m. Peter and Allan Cartwright were together until around 7:00 p.m. when they returned to the hospital where Peter hoped to get more money to buy more beer. They had consumed about 8 or 9 beer each in that 2 ½ hour time frame. I also accept Mr. Cartwright's testimony that Peter was scared to go to the hospital because he had had a few drinks and they would keep him in. He said that Peter was also upset about seeing him leave.

While Allan Cartwright was in the smoking room at the psychiatric ward Peter went to the telephone and called the R.C.M.P. detachment and spoke to the receptionist, Heather

McKinnon. The tape recording of this conversation was played at the inquest. Ms. McKinnon, throughout, was courteous with Mr. Stevenson but clearly indicated that she could not do anything about his having to remain at the hospital, something that Peter did not want to do.

One of the main delusions Peter suffered from was based in part on reality. Peter did receive a trust amount of $5,000.00 from Manitoba Hydro upon attaining the age of majority. He spent his funds quite quickly and continued to be of the belief that he had been cheated of these monies and that the R.C.M.P. had this money and wouldn't return it to him. There apparently had been numerous phone calls to the R.C.M.P. and it is apparent that Ms McKinnon knew who Peter was and treated him in a friendly, patient yet firm manner.

Peter was then seen slamming the phone onto the receiver and proceeding in the direction of the kitchen/lounge area. By now he was quite agitated.

The unreliability of eye witness evidence certainly was clearly demonstrated as there are a great many inconsistencies between what each of the people present testified as to what occurred within the next crucial half hour.

The Code White

Initially present there was nurse Cindy Fortin, nurse Erin Bukowski and aide Dan Pommer. When Mr. Stevenson started to become agitated there was a call placed to E.M.S. (Emergency Medical Services personnel) who also act as hospital security. Darren Baker and Barry Early were the two E.M.S. workers on duty and they responded.

Darren Baker had just become the supervisor for E.M.S. the day before Peter's death. He had started his training as a first responder in 1993 (150 hours) and then in 1995 after a further 500 hours of training became an emergency medical technician. He continued with the fire department between 1998 and 2002 when he once again requalified as an E.M.S. or paramedic.

Barry Early completed his paramedic's training in July 2002 and had been a first responder for 8 ½ years before that. Barry Early is a reasonably large man. Both Mr. Early and Mr. Baker expressed the opinion that it would be preferable for properly trained security personnel to look after security and not place paramedics in that position. They also felt ill trained and not equipped to know how to properly secure a violent individual.

Cindy Fortin

Nurse Fortin testified that when she first came to the psychiatric ward to do her senior practitioner's course from May to July, 2004 that Mr. Stevenson was already a patient. In this respect she must be in error as Mr. Stevenson was not admitted until June 1, 2004. She further states that a majority of the time she was the nurse responsible for Peter. Although

she received the medical charts, records of his prior stays at the hospital and she was aware that he was involved with other support agencies, she never personally contacted them for more information. Although there was a query F.A.S.D. noted on the files, she wasn't aware of any definitive diagnosis herself.

This is her version of what occurred after she called the E.M.S. because Peter had pounded on her desk, raised his voice and punched his hand. She had given the E.M.S. the background when Peter came out of the smoking room and went to the pay phone. During this time his friend was asked to leave and he did. She remembered Peter slamming down the phone and turning to the kitchen area. At this time she was by the nursing station and she says Erin Bukowski, Dan Pommer, Barry Early and Darren Baker were in a semi circle around the phone.

She says that Peter was yelling, agitated and at one point he picked up a chair and threw it at a window. She says it was the chair closest to the stove which was thrown and that it went against the window closest to the stove. She did not note any damage but does indicate that a small gouge photographed by Cpl. Spencer had not been there before the incident. The chair was thrown in a side motion towards the wall.

She states that Peter picked up another chair and that Dan Pommer grabbed the chair's legs and Peter let it go. Peter then reached for another chair but Dan put his hand on it and the chair remained. She states that Peter then got Dan against the wall, the one with the window.

That is when the two E.M.S. grabbed Peter's arms away from Dan. She also had to get a different patient back to her room during this time frame.

When she got back she states that Peter was on the floor on his stomach with his face turned. That Barry was holding his right arm or shoulder, Darren was holding the left arm and that Dan was holding the feet. Her version was partially obstructed by the table, chair and couch between her position and theirs. She said she called the code white as directed by Barry.

A code white is the signal for a violent situation or patient and is a request for any available personnel to respond. She says that Nicolette Kennedy came in after the code white was called; that she filled her in and asked her to phone the R.C.M.P., as in her opinion they were not being able to restrain Peter successfully; she felt that Barry was being lifted up by Peter. She did not recall anybody on top of Peter. She recalls the table and chairs being pulled back for more room. The R.C.M.P. then arrive, they were buzzed in and they handcuffed Peter. The E.R. doctor, Warraich had been called and he showed up at some point.

When the R.C.M.P. arrived Peter was still on his stomach on the floor, still resisting, just trying to get them off his arms and trying to get up. That was when he was handcuffed. She heard one of the nurses say to check if he is breathing and that is when his bladder let go. He was checked again and found not to be breathing and a code blue was called (that is a call for the team to come up from E.R. with the crash cart). Although she couldn't say how long Peter was struggling she did verify that notes she made in consultation with nurse Bukowski showed the code white call at 19:07 and the code blue at 19:28 for 21 minutes. These times

were checked with the switchboard. When questioned by Mr. Green, counsel for the Regional Health Authority, she did agree that Peter did appear to settle somewhat before the police arrived and that he was more calm and was saying "I'm sorry, I'm sorry". She states that his breathing was checked twice, first time he was and later, he was no longer breathing. She testified that it was possible that some other staff person may have disconnected Peter's phone call but she didn't do it. There is a switch at the nursing station that disconnects the pay phone.

Peter was restrained on the floor with his head pointing to the stove and his feet towards the table – he was more towards the counter than the wall.

Erin Bukowski

Since the incident nurse Bukowski has changed her name to Wilson. She had on prior occasions seen Peter become agitated and it was necessary to intervene. She had walked with him to calm him down and usually he would settle down. On one occasion he had grabbed her by the arms and shoved her. He had asked for seclusion and he had calmed himself down in under 10 minutes. She stated that Peter was impulsive with his money so he was on a budgeting plan. She also only suspected he was afflicted by F.A.S.D.

She states that she noticed he was getting angry when he was on the phone and she wanted to talk to him and that she had asked Cindy to disconnect.

She confirms much of what nurse Fortin described and after the 3 chairs incident she described Peter and Dan getting tangled up against the wall with Peter having his left hand against Dan, holding him and his right arm arched back and it appeared he was about to strike Dan and that is when she grabbed Peter's right wrist, but only for a second as by then the E.M.S. personnel had a hold of Peter, one on the left side and one on the right side. They got Peter down to his knees and then down on his stomach. She also states that each E.M.S. had an arm and that Dan had his legs with his knees bent initially. Peter's head was near the stove and his legs were near the table. She described Peter as being initially angry and tense and later he said, "I'm sorry" and that it appeared he was relaxing and regaining some control i.e. that he was reaching the tension reduction phase or that he was physically and emotionally spent. She says that she sat by his head and tried to reassure him by saying that the R.C.M.P. were coming to take him to cells. The police came, put him in handcuffs and they were waiting for a doctor to clear him – it wasn't long before one of the E.R. nurses who had responded to the code white noted that he was not breathing – the R.C.M.P. removed the cuffs and the code blue was called. She recalled that people had responded to the code white including some nurses, a lab worker, and an off duty E.M.S. worker. She stated that nobody placed weight on his body except for his extremities; she did not see his arms behind his back until cuffed by the R.C.M.P.; that nobody was on his back and that she doesn't recall anybody reaching across his back during the incident.

She saw that he had mucous maybe out of his nose, like he had blown his nose, like a large amount.

Daniel Pommer

As in the case of all witnesses who were at the scene and who testified at the inquest Mr. Pommer had given a statement to the R.C.M.P. shortly after Mr. Stevenson died on September 2, 2004. In his testimony he indicated that when Peter was confronted with the rules he became quite agitated in the past and it appeared that it was his position that they were trying to get the point across that he had to follow the rules, policies and procedures of the ward and that he was not to come in when intoxicated. In the past, Peter had come to the ward intoxicated and he had come in late for passes. Mr. Pommer was of the impression that there had been outbursts of aggression in those cases previously by Peter punching his hands on the table, swearing and the like. In the past, conversation could calm him down and the situation could usually be de-escalated. It was Mr. Pommer's impression that the E.M.S. that were called were located on the same floor and that they responded within a minute or so. He also recalled that the three of them, being himself and the two E.M.S. members were in a semi circle around the pay phone and that this semi circle kind of approached the pay phone. It was his impression that he had backed up but that the E.M.S. were within five feet of Peter while he was on the phone. It was his impression that the focus was on letting Peter know that their rules were going to be enforced. He also recalled Peter slamming the phone onto the receiver. He also described Peter walking on the right side of the kitchen table between the table and the counter, grabbing a chair and slamming it against the wall, that is that he threw it. He describes the incident with the second chair, that is that Peter grabbed it and that he grabbed the opposite corner and he was able to get it out of Peter's hands. He also concurs that Peter grabbed the third chair and that he put his hands on the arm of the chair and that Peter let it go. He then described that Peter came at him and that he was expecting

to get punched as Peter's left arm was extended forward and it looked like his right arm was about to take a side arm swing at him. He then described putting both of his hands against Peter's chest when Peter grabbed his shoulder and pushed him back two steps and he was required to back-pedal and then he was banged into the wall. As is common in situations such as this Mr. Pommer candidly admitted that he did not know where everybody else was and that he had a tunnel vision focus towards Peter. He also indicates that he had no recollection of what occurred from the time he was banged into the wall until he was on the ground at Peter's feet holding his legs. He describes the fact that he had both of Peter's legs bent towards his buttocks for a short period of time and then straightened them out, crossed them and was holding them in that fashion. In his statement to the police Mr. Pommer had indicated that Mr. Stevenson had taken a swing at him and that he had blocked the punch. This was not stated in his testimony. Mr. Pommer did not state either in his statement or in his testimony that nurse Bukowski grabbed Peter's hand. He also describes that Barry Early had his hand on Peter's shoulder and that Darren had his hand on his other shoulder and wrist. Mr. Pommer also remembers asking a nurse to take over his position in order to assist Barry and grabbing Peter by the wrist which he held to the floor so that Barry could have a free hand. This was just before Peter's arms were by his side. During his testimony he indicated that he estimated that the major part of the struggle, i.e.the time required to restrain Peter to the floor until the police arrived was approximately five minutes. In his statement to the police he indicated that the time frame was five to eight minutes but that he was having a tough time to approximate it and he said then that he was just roughly guessing between the five and eight minute period. This is inconsistent with the times apparently noted by the switchboard between the calling of the code white and the code blue which is 21 minutes.

When asked whether or not he turned off the phone Mr. Pommer indicated that he did not turn off the phone and does not recall this request or discussion to that effect.

During his testimony Mr. Pommer does not relate the role that Stewart Carruthers played in restraining Mr. Stevenson, however he does mention in the statement to the police how Mr. Carruthers helped by holding onto one of his legs that had gotten loose. Mr. Pommer also seemed to indicate a significant struggle by Mr. Stevenson and that he went quiet just before or at the time the police arrived. That he was handcuffed and that he urinated either just before or at the same time. That is when he stood up and his focus went back to the ward to look for other patients but he noted that there were none in the area. He indicated that he never saw anyone place any weight on the head, neck or torso of Mr. Stevenson. It was his position that he did a visual check at the time the handcuffs were placed and that he saw Peter's chest going up and down and concluded that he was breathing. When he came back after walking around for a minute to a minute and a half, Peter was not breathing and the code blue was called.

Darren George Baker

Darren George Baker, one of the two paramedics that attended in their role as security, described the events in the following fashion. He recalled receiving a call and attending to the ward and speaking to nurse Erin Bukowski who briefed him basically that Peter had been drinking. They discussed getting the friend, Mr. Cartwright, to leave before doing anything with Peter. They had no specific plan on what to do with Peter. He recalls Peter going to the pay phone and he was of the opinion that it was Dan Pommer who actually asked Mr.

Cartwright to leave. Darren Baker advised that while Mr. Stevenson was on the phone he talked loud enough to let Mr. Stevenson and the R.C.M.P. know that Peter should be off the phone. While listening to the tape of the conversation you cannot hear Mr. Baker's comments. Mr. Baker felt at that point, that the plan was to get him off of the phone and into his room to settle him down and to be able to deal with him face to face and to get him to understand that he was not going out again. This plan had been worked out mainly between Erin and himself. In hindsight, he now concludes that he can see no benefit in having Peter get off the phone and he speculated that maybe it was him trying to control the situation. Mr. Baker then stated that he asked Mr. Stevenson to get off the phone and that Mr. Stevenson then slammed the receiver down. Thereafter Mr. Stevenson got up and walked abruptly to the kitchen. He also describes the path taken by Mr. Stevenson as being between the tables and the counter. He describes himself as being behind the telephone and somewhat to the right of it and Ms. Fortin being somewhere near the post centrally located between the nursing station and the telephone. He also describes the fact that Mr. Stevenson picked up the three chairs and that he threw the first one by the window. He then indicates that he did not know exactly what happened but at one point Mr. Stevenson went at Dan Pommer and pushed him against the wall area and that is when Barry Early got involved. Mr. Baker acknowledged that in his statement, he had stated that Mr. Stevenson had pushed Mr. Pommer but he did not have any specific recollection of that when he testified. Mr. Baker states that while Barry Early was on the right and Dan was on the left of Mr. Stevenson, he was behind Peter when he came in to help. He put his arms across his right shoulder and over to his left shoulder across his chest. They struggled and it seemed to happen fast but it was kind of like a slow take down that took somewhere between ten and thirty seconds. He states

that once Mr. Stevenson was on the ground, they maintained him on the ground in the prone position. Mr. Baker then describes his role in holding down Mr. Stevenson in a somewhat a different way than the others. He describes his body being over the body of Mr. Stevenson, that is, he was over Mr. Stevenson's buttocks and the small of his back with his weight projected to his arms while holding both Mr. Stevenson's left and right wrists which were now at Mr. Stevenson's left side. He indicated that he had his leg between Mr. Stevenson's two legs and that his hip was on Mr. Stevenson's hips and his stomach was on Mr. Stevenson's back, on an angle across Mr. Stevenson's body. This was demonstrated by Mr. Baker on counsel, Dean Head, who kindly agreed to volunteer for the purpose. Mr. Baker then indicated that Mr. Stevenson got his right arm free and that Barry Early then got a hold of it. It was clear that Mr. Baker had exerted a tremendous amount of effort in trying to restrain Mr. Stevenson as he described himself as completely physically and mentally spent at the conclusion. He also remembered Barry Early calling for the code white and that others showed up after this code was called. It is his testimony and his recollection that throughout the majority of the restraint period he remained in the position that he described. He also recalls Peter slowing down in his struggling and that the R.C.M.P. then showed up. Mr. Baker's position was that when Mr. Stevenson stopped struggling he would stop resisting him. Once the police arrived and the handcuffs were placed on Peter, Mr. Baker moved to the side. He also confirmed that Mr. Stevenson was not struggling when the R.C.M.P. put the cuffs on and that he was just laying there. He also confirmed that at the beginning of the restraint that Peter was swearing and using vulgarities and shouting for them to get off of him. At the end of the restraint he recalls Peter saying "I'm sorry, I'm sorry, I'm sorry" and it was clear to Mr. Baker that Peter was tired and that they were all in fact tired. He

remembers the progression of the situation from Peter being agitated to calm but still breathing. He remembers seeing some saliva or mucous out of his mouth, kind of bubbling. He also recalls that at the height of the struggle, he and Barry were on Mr. Stevenson's right arm and that Debbie Patenaude and Jim Howatt were on the other side and said that they got his other arm down to the side. He also remembers one or two people on his legs, the left leg as he didn't have control of that. He was of the opinion that it took five or ten minutes for the police to arrive, although time is difficult to keep track of in that type of situation. He just remembers being very tired when the police arrived. He also observed that Mr. Stevenson urinated just before the police arrived and that when he lifted his leg up he noticed his pants were wet. He says that at the time he didn't feel it; he just saw it. He testified that just before he noticed that Mr. Stevenson wasn't breathing; that he was handcuffed; he remembers talk of checking him out at the E.R. and discussions about this before the R.C.M.P. would take him; that it was a very short period of time between this and when it was noticed that he wasn't breathing, "maybe three minutes, if that". He was of the opinion that it was the head nurse that noticed that Mr. Stevenson wasn't breathing and that is when the handcuffs were taken off. Mr. Baker impressed me as a sincere and honest witness who displayed considerable emotion in the giving of his testimony. Mr. Baker also testified that although he had heard of positional asphyxia, that he had received no training on that but that he was reasonably certain that he wasn't pushing down on Mr. Stevenson and that the force was directed mainly at holding Mr. Stevenson's arm. At no time did he hear Mr. Stevenson complain that he couldn't breathe.

It is difficult to reconcile Mr. Baker's testimony with that of the two nurses and the nurse's aide who testified that they did not see anyone over Mr. Stevenson especially when Mr. Baker indicates that he was in that position throughout most of the period of the restraint. Mr. Baker's testimony is consistent with the statement he made to the R.C.M.P. on the evening of Mr. Stevenson's death. In the statement made to the police he also indicated that his right knee was also being used for leverage against Mr. Stevenson's body.

Barry Early

Barry Early was the other paramedic who attended at the scene initially. His recollection is somewhat at odds with the evidence of the nurses and his partner. In particular, he advised that he doesn't recall anyone being in a semi circle around Peter while he was on the phone, more specifically, he states that he was back by the wall next to the entrance of the ward. He also describes Peter as taking a somewhat different route from the phone and he describes him as picking up the first chair and throwing it in the direction of the cupboards toward the fridge from the table nearest the telephone. This is different from the evidence of the others who described Peter picking up the chair and throwing it or swinging it at a window or near the window. Mr. Early also describes the route Mr. Stevenson took as on the opposite side of the tables between the tables and the nursing desk and not between the table and the counter. Mr. Early then describes Peter taking a second chair and swinging it towards the window and striking the window on the left of the diagram with a chunk coming out. When shown the actual photographs of the scene he then agrees that he must be mistaken and that it actually hit the area next to the right window where the chunk was actually missing from the edge of the window. He does, however, describe Dan Pommer as being beside Mr. Stevenson and

that he was trying to restrain or calm Peter down. He describes Peter grabbing him and having both of his hands around Mr. Pommer's throat and that Mr. Pommer managed to get away. This is at variance with what was described by Mr. Pommer and the nurses. Mr. Early then states it was Darren and Dan that grabbed Peter by both arms and kind of got him to the floor onto his knees and then into the prone position. Mr. Early does not indicate that he had any roll in getting Mr. Stevenson down to the floor and this is contrary to Mr. Baker's testimony where he advises that by the time Mr. Stevenson was taken down to the floor that Mr. Early had grabbed one of his arms. Mr. Early indicates that he was the one that pushed three tables towards the nursing desk to make more room and that he then got on Mr. Stevenson's right side trying to hold onto his right shoulder and right arm. He confirms that Darren was kind of like lying on his mid back but that Mr. Stevenson was very, very strong and was kind of lifting him up. He describes Mr. Stevenson as being one of the strongest individuals he has ever had to deal with. Mr. Early does confirm that Dan had kind of flexed one of Peter's legs and that Dan was kneeling on the floor holding onto that leg. He states that Darren would have been more like on Peter's left side, his hands holding onto the left shoulder and the left arm. Mr. Early describes Mr. Stevenson as hollering repeatedly to let him go and that he then stated, " I'll be good". He felt that he had called for the code white fairly fast within the first seconds of the restraint having started. He thought it would have been a bit before 7:20 p.m. He has some recollection of Stu Carruthers, a lab technician and two members of the R.C.M.P. coming up. He also remembers nurse Chris Anderson, nurse Margaret McGonegal, nurse Huculak and Debbie Patenaude being there. Debbie Patenaude was trying to hold Mr. Stevenson's left arm down. He confirms that by this time Darren had moved closer to the waist trying to restrain the left leg and that Erin Bukowski was also

there. It was his evidence that there were probably four or possibly five people restraining Peter when the police arrived. He felt that Peter was still conscious when the police arrived and that he was saying, "let me go, let me go, I'll be good". This continued until about a minute after the police arrived. He felt that Peter had calmed down stating "I'll be good, I'll be good," after the cuffs were on. The police then stood back to determine if Peter had to be seen by a doctor and that he recalls someone phoning Dr. Medd, possibly Debbie Patenaude or Erin Bukowski. It was his recollection that it was Debbie Patenaude who first noticed something wrong and said, "I don't think he's breathing".

Nicolette Kennedy

Nicolette Kennedy was one of the nurses who was to commence work on the next shift at the psychiatric ward. She too was a very junior nurse having completed her Bachelor of Nursing through Brandon University in the spring of 2004 and started work in The Pas on June 7, 2004. She testified that it was about five or ten after 7:00 p.m. when she first arrived on the psychiatric ward at which time she saw that Peter Stevenson was on the pay phone. She also saw that Erin was there with two personnel from the E.M.S. Although she reviewed her notes, she indicated that she didn't remember much of the events now. She indicates that she went to the back of the nursing station to put her things away and that when she walked out of the office part, Peter was still on the phone. She describes Erin and the two E.M.S. personnel in the same area but that she was situated at a place where she could not hear Peter at all. She believes that she saw Dan Pommer turn the pay phone off, in particular she saw him come behind the nursing desk where the switch is but that it's kind of blurry in her mind. She remembers seeing Pommer reaching underneath the desk. She remembers Peter walking

to the kitchen area and swinging or throwing a chair in the window area and that the other people were to the back and side of him. She recalls someone then asking for the code white to be called and that she was near Cindy Fortin and that it was Cindy who called the code white. She remembers the E.M.S. asking that 911 be called. She recalls calling 911 herself and that there was a struggle that happened very quickly. She remembers Dan and the E.M.S. being on the ground where Peter Stevenson was but she is not sure who was where or how he was being held and that she didn't believe anyone was on top of Mr. Stevenson, although her view was obstructed by the kitchen table. She was then required to go and assist another patient who came out. By the time she had finished dealing with the other patient, others from the code white had arrived and the R.C.M.P. were also present. She remembers Mr. Stevenson having been incontinent and that she was involved with moving the table and that she went to get the towels to clean up the urine. She doesn't remember Peter moving at that point in time.

Debra Mae Patenaude

Nurse Debra Mae Patenaude was one of the people who responded to the code white. She is the head nurse of the emergency room and has over 22 years of experience. At the time, in 2004, she was on a ten hour shift and nearing the end of completing her shift. She came up with nurse Karen McKay who also worked in the E.R. She remembers that when she arrived at the psychiatric ward the two paramedics and Dan Pommer were trying to get control of Mr. Stevenson's arms and legs, keeping him prone and that Mr. Stevenson was fighting back with his arms and legs flailing out mostly trying to hit at them. Nurse Patenaude helped to control one of his arms and she recalls Dan trying to control his legs. She had difficulty just

trying to hold one arm down so that he could get more control of the arm. She remembers nurse McKay on the other side trying to help with the other arm and that there were a total of five people trying to restrain Mr. Stevenson. She doesn't know the exact time frame but that it seemed long to her. He did seem to calm down more eventually and by the time the R.C.M.P. arrived and applied the handcuffs he had calmed down completely. She cannot say whether or not anybody reached across his back. Ms. Patenaude agreed with Mr. Green's suggestion that Mr. Stevenson was struggling mightily and that he continued to struggle for a few minutes after she arrived, trying to break free and fight. She was convinced that at the time the handcuffs were applied, and prior to her leaving to call for the E.R. doctor to assess him, that he was breathing. She believes that she may have spoken to the E.R. doctor for about two minutes before she returned. At that time he was too still, he was not breathing.

Marjory Patience

Nurse Marjory Patience, a registered nurse with 32 years experience in The Pas, attended upon hearing the code white. She personally did not become involved in the restraint and looked on and assisted by obtaining gloves and the like. She remembers Peter moving and resisting, moving his upper body and trying to move his legs and hips. There were already quite a few people there when she arrived. She was not able to provide many specifics as to the actual restraint and didn't specifically recall if anyone was across his back. This is contrary to the answer to a question during the course of her statement taken the night of the incident by the R.C.M.P. In that particular statement there was question 9. "Was there anyone on top of his back?" And her answer, "um, I think there was one person across the

back but I, I'm not sure whether he was actually on his back or leaning across the back, I can't be sure." Her answer to this question is consistent with the evidence given by Darren Baker.

Nurse Karen McKay who responded to the code white had subsequently moved to Alberta and was not called as a witness. By agreement of counsel her statement included at page A35 of Exhibit 2 was reviewed by the court. Ms. McKay's evidence accordingly is that she did know Peter Stevenson and that he was extremely violent this time and that she had never seen him like that before. As she assisted in attempting to restrain Peter he did kick her in the left wrist and she confirmed that it was bruised where he had kicked her. After being kicked, she sat on his leg to help restrain him.

Stuart Allan Carruthers

Stuart Allan Carruthers was an off duty paramedic and employed in that position since 2002. He was visiting a friend at the hospital when he heard the code white. He attended at the psych ward where one of the nurses was holding the door open. He could see Peter on the ground with two paramedics trying to hold onto his arms and Dan trying to hold his legs. Dan was across his legs, probably kneeling across his legs, possibly on top. Dan looked as if he was having a tough time. He went and held onto one of Mr. Stevenson's legs with his hand. He remembers Barry and Darren trying to hold onto the arms but cannot be specific as to their exact positions as he had his hands full holding the leg. He remembers Mr. Stevenson was yelling that he didn't want to be there, he didn't want to be held and that even with four of them it was still difficult to restrain him. He remembers Barry Early sweating

quite a bit and that is was not easy to restrain him. When the police arrived his hands were placed behind his back and he was handcuffed. As far as he can remember he says it was just the four of them and he doesn't remember any nurses assisting in the restraint. He also describes the same sequence of events. Mr. Stevenson was initially being violent and resistant and after awhile he said, "I'm sorry, I'm sorry, I'll stop" but that they continued to hold him. He testified that he quit yelling and that he had urinated on the floor. Just after that point in time is when the R.C.M.P. arrived and there was not a huge delay between the time the police arrived and the time that he was handcuffed. Mr. Carruthers stood up and then walked away towards the door. Once he was handcuffed, Peter was quiet, calm and didn't kick anymore. It was after that that Debbie Patenaude went and checked on him and said that his lips were blue and that he was not breathing. Mr. Carruthers had also made a statement to the R.C.M.P. on September 2, 2004 and in the statement he initially had said that when he entered the paramedics and some nurses were on top of him trying to restrain him.

Jason Prettie

Constable Jason Prettie was one of the two R.C.M.P. officers who attended at the psych ward. He testified that he arrived at the hospital at 19:18. Upon arriving at the psych ward he was buzzed in and there were several people on the floor holding a person down on the floor. He recalls specifically that one person was on Mr. Stevenson's legs, one person was on Mr. Stevenson's back and one was near his head. He testified that they were holding Mr. Stevenson's hands behind his back, with one individual having both hands on Mr. Stevenson's arms and with their knees across Mr. Stevenson's back and that someone had

their hands on top of his shoulders holding him down. Mr. Stevenson was lying face down with his face to the left. Constable Prettie advised that after he applied the handcuffs everybody got off of him and cleared away. He states that he then went to look at him and could see that his lips were lightly blue and he inquired if he was okay. He testified that he did not see Mr. Stevenson move at all nor did he hear anything and that there was no resistance in the handcuffing. It was then that a nurse tried to get a carotid artery pulse and called for the code blue. Constable Prettie confirmed that he made no notes at all as to what he observed when he first arrived and that he was testifying entirely from memory but that he has a clear recollection even though it was two year ago. He is of the opinion that they stood around for a few seconds, 10 to 20 seconds, after the cuffs were on. He didn't recall whether or not Mr. Stevenson had urinated. It was his estimate that the cuffs were on Mr. Stevenson for a period of 1 or 2 minutes only and that he removed the cuffs immediately when requested to do so.

Gabriel Simard

Constable Gabriel Simard was the other R.C.M.P. officer who attended at the ward. He has a similar note of 19:18 when he attended at the fourth floor and observed Mr. Stevenson on the floor with several hospital staff still subduing him. From what he can remember there was at least one person on each arm and the individual was face down arms in prone position sort of spread eagle. There was a person in a crouch or kneeling position holding his arms down and maybe the legs were held down as well. He cannot specifically remember if anyone was kneeling on him. He did not remember anybody on his torso at that time. He testified that when they arrived that Mr. Stevenson appeared to be motionless and he said nothing. It was

upon his instructions that Constable Prettie handcuffed him while Constable Simard tried to obtain more information from the staff. He says that a short time later that it was noticed that he was not breathing and that Constable Prettie took the cuffs off him when asked to do so and that is when C.P.R. was started. He is of the opinion that the cuffs were not on for more than a total of about 30 seconds.

From the evidence received it appears clear that Mr. Stevenson was being restrained in a prone position by a minimum of 4 and perhaps up to 6 people during the course of the struggle. The struggle, during which time Mr. Stevenson was maintained in a prone position, was probably for a period of a minimum of 10 minutes and perhaps up to 14 minutes. This was arrived at by the time the code white was called which was 7:07 p.m. and at which time Mr. Stevenson had been struggling for probably about thirty seconds to one minute prior to then and we know that by the time the police arrived and placed the handcuffs the struggle was over, although he was still being restrained. The police arrived at approximately 7:18 p.m. at the hospital and maybe onto the ward and the cuffs remained on him from 30 seconds to 2 minutes afterwards during which time Mr. Stevenson remained in the prone position. Accordingly he was on the floor in the prone position probably somewhere around 11 or 12 minutes. It can also be concluded that Mr. Stevenson was demonstrating extraordinary strength and appeared to be struggling with all his might as even the 4 to 6 people who were restraining him had an extremely difficult time of it. I have also concluded that in all likelihood paramedic Baker did have his body placed diagonally across Mr. Stevenson's back from his buttocks at one end to his left should at the other end with most of his weight directed towards the wrists of Mr. Stevenson. He would have been in this position for a

significant portion of the time during which Mr. Stevenson was struggling. The actual struggle portion of the time during which Mr. Stevenson was in a prone position was at least around 9 to 10 minutes as he had ceased struggling and had calmed down considerably before or approximately at the same time the R.C.M.P. arrived and placed the hand cuffs on him.

I am also satisfied that between the short period of time during which Mr. Stevenson was handcuffed ,or just prior to that, and the time it took for nurse Patenaude to call for the E.R. doctor to come and check on him, a period of probably less than 2 minutes, Mr. Stevenson stopped breathing and his heart stopped beating. Once that occurred a code blue was called. This was noted as being at 7:28 p.m. Could the R.C.M.P. have been at the hospital for as long as 10 minutes before the code blue was called? If so, then either Mr. Stevenson was restrained or in the prone position for a longer period and the response time calling the code blue was longer or times were not properly noted.

The Code Blue

It is clear from the evidence that as soon as it was ascertained that Peter Stevenson was no longer breathing that there was a sudden drastic and immediate change in what the staff did. It became an all out effort to save his life immediately upon a code blue being called. A code blue is the signal that someone is not breathing and is having a cardiac arrest.

Ideally it is hard to imagine a better scenario for survival if one were to have a cardiac arrest. Mr. Stevenson was surrounded by three experienced paramedics, he had the head emergency

nurse there as well as several other nurses and the emergency doctor on call was actually on his way up to the ward when the code blue was called. Notwithstanding this, there were some areas where improvement needed to be made. In particular, the psychiatric ward did not have oxygen on hand; neither did it have the required airways that are needed in resuscitation attempts. There was a further problem with the suction machine as it did not work, probably because of the fact that the battery had worn down. There was also no appropriate stretcher on or near the ward. These made life-saving efforts somewhat more difficult in the initial couple of minutes. All of these deficiencies have now been rectified by the hospital. There are now airways kept in the nursing office as well as a supply of oxygen available. There has also been a stretcher placed on the fourth floor just outside of the psychiatric ward doors. In addition there is regular checking and monitoring of the suction device.

Of course time is of the essence when a person's heart has stopped. It is critical to re-establish an airway and to have the heart circulating as quickly as possible. The prompt availability of appropriate airways and oxygen is therefore important in the vast majority of cases. I am satisfied that the hospital personnel initially on the scene did the best they could with what they had to work with. C.P.R. was immediately administered and it appeared as though Mr. Stevenson's airway was open. On the calling of the code blue, the crash cart which came from the emergency room immediately responded. The evidence has seemed to indicate that they arrived very promptly. It was Barry Early's testimony that he believed it took possibly 40 seconds from the calling of the code blue. Nurse Huculak a registered nurse with 20 years of experience, of which three to four years were in the emergency room and

with advanced cardiac life support training, responded to the code blue from the E.R. near the end of her shift. She said that she went to the crash cart and to the fourth floor and that it took less than 30 seconds to get to the elevator with the cart and that there was no difficulty by using the cardiac key to go up quickly. Daniel Pommer commented that the E.R. team was quite quick, "within a minute or two," is what he told the court. Nurse Margaret McGonegal, a nurse who has been working in The Pas for 26 years and is now in the E.R. attended to the code blue with nurse Huculak. Although she does not give any time estimates she said that there were no difficulties in going into the ward and that the doors were open when they got there. On the basis of the evidence I heard I am reasonably satisfied that the crash team arrived up on the fourth floor at the psych ward probably within about one minute after the code blue was called. Dr. Warraich testified that he had been called to the ward prior to the code blue being called and when he arrived Mr. Stevenson was still lying on his abdomen and handcuffed. Dr. Warraich said he went and sat on the floor and noticed that the patient was not breathing, there was no pulse and he asked that the cuffs be removed. After that, the code blue was called and the stretcher was brought to the fourth floor. None of the other witnesses who testified seemed to recall seeing him or that it was Dr. Warraich who noticed that Mr. Stevenson wasn't breathing. In fact, none of them seemed to recall him being on the scene until after it was ascertained that Peter Stevenson was not breathing. Nurse Patenaude described that she went to telephone Dr. Warraich to come up to check on the patient and she had returned immediately to Mr. Stevenson and ascertained that he wasn't breathing. This would have occurred while Dr. Warraich was on his way up if he had immediately left the E.R. to attend. The evidence would support, however, that he was there before the crash team arrived and we can estimate that the crash team arrived within one

minute of the code blue being called and that the code blue was called at 19:28. Margaret McGonegal testified that she was the one that hooked up the heart monitor and that the heart monitor showed a start time of 7:31p.m. Therefore, the time frame could be as little as just over one minute and as much as almost three minutes depending on the number of seconds that had lapsed in the first minute and the last minute noted. Unfortunately, the heart monitor showed that Mr. Stevenson's heart was asystolic, which means that there was no heart beat whatsoever and the monitor showed a flat line and as such it was inappropriate to attempt to defibrillate. We know that Dr. Warraich tried to intubate Mr. Stevenson while on the fourth floor and that he was unsuccessful in doing this. In his recollection Dr. Warraich indicates that he attempted to intubate on one occasion only whereas nurse Margaret McGonegal recalls two attempts at intubation which both failed. Nurse Patenaude recalls one attempt to intubate while Peter was on the floor. Nurse Patience recalls assisting with the attempted intubation; it is her recollection of the situation that she had a number 9 endotracheal tube, it was patent and inflated, she handed it to Dr. Warraich; that Dr. Warraich looked in the patient's mouth, that you have about 20 seconds to do this but that the tube wouldn't go in. Then that he tried a second time with a smaller tube and that he was not successful. It was after that that a combi tube, a device used by the paramedics to secure an airway, was put in place. A gurney was secured, Mr. Stevenson was placed upon the gurney with the assistance of the paramedics and the R.C.M.P. and the crash team started to bring Mr. Stevenson down to the emergency room. All the while aggressive C.P.R. efforts were being continued with the compressions being done by nurse Huculak. While he was on the fourth floor he was administered, on the instructions of Dr. Warraich, epinephrine and atropine as soon as possible.

Efforts at resuscitation continued in the E.R. room and Dr. Grabbey, the anesthetist attended as well. A chest x-ray was also taken. At 8:18 blood samples were analyzed by the lab which showed that Mr. Stevenson's sodium level was high as was his alcohol reading. An arterial blood gas test was also conducted which indicated that Mr. Stevenson was suffering from acidosis; in particular his pH was observed to be 6.852, his PCO2 was elevated at 92, his PO2 was very low at 59.1, and the HCO2 was low at 16.3. At no time during the entire period of resuscitation did Mr. Stevenson ever show any signs of life. Essentially by the time that he was first assessed by those on the psych ward as having stopped breathing and having no pulse he had died.

Dr. Warraich who was the physician at the E.R. was questioned as to his qualifications and expertise. It was his evidence that he completed a four-year degree in 1987 in Pakistan. In 1991 he moved to Newfoundland where he worked from 1992 to 1998 and since that time he has been in Manitoba. He has practiced in general surgery and orthopedics. Between May or June of 1994 and March 2006 he worked in The Pas, not as a regular doctor but on a rotation where he would be two weeks in Winnipeg and then two or four weeks in The Pas as the E.M.O. emergency physician. He worked the rest of the time at the Victoria Hospital but not in the emergency department. He also did some emergency work off and on through the summer of 2005 in Brandon and in Steinbach last winter. He advised that both in Newfoundland and Labraor he worked in the E.R.. He has also worked trauma and in the I.C.U. in Winnipeg. On September 2, 2004 he had just started work at 6:00 p.m. When he was asked about his experience at intubation he advises that he can only recall two occasions, this being one of them, when he was not successful in intubating a patient. When asked how

many times he has actually successfully intubated a patient his answer was ambiguous and that he said it was difficult to say. He did do training with an anesthetist at the Saint Boniface Hospital and the anesthetist had said he was okay. He could not even estimate whether it was closer to five or closer to a hundred times that he had intubated a patient. I found that Dr. Warraich was somewhat evasive on this point. When asked about the fact that Mr. Stevenson had an acidic pH in his blood his response was, "the patient has quite high CO2 and his respiratory system is not working". He acknowledged that he did not administer any bicarbonates in this case but said that same would not really be feasible because Mr. Stevenson's heart was not functioning at all. He also indicated that it wasn't he that ordered the arterial blood gas but that it was Dr. Grabbey and that it was more than thirty minutes after they had started the C.P.R. Once Dr. Grabbey obtained the arterial gas results that is when they determined to stop any further efforts at resuscitation. Dr. Warraich was allowed to testify by video format from Winnipeg and this was done by agreement of all counsel. It may be that the quality of his evidence was affected by this procedure. It was at times somewhat difficult to understand Dr. Warraich although this may have been a combination of the technology used and the fact that English does not appear to be Dr. Warraich's first language.

Cause of Death

Although we can reasonably ascertain the circumstances surrounding the time of Mr. Stevenson's death the question persists as to what caused his death. Mr. Stevenson's body was forwarded to Winnipeg for an autopsy which was performed by Dr. Littman the following day at around 4:00 in the afternoon. Dr. Littman's cause of death of sudden

cardiac arrest really doesn't tell us much more than the fact that Mr. Stevenson's heart stopped functioning suddenly. The autopsy did not reveal any anatomical reason for his heart to have stopped. The only marks on his body consisted of small bruises on Peter Stevenson's upper left arm and that these are consistent with having been caused by finger tips and the amount of force required for such a bruise is variable and at times may not require all that much force especially if there is movement on the part of the deceased at the time the force was applied. This is consistent with the description of how he was being restrained. Dr. Littman concluded that everything was quite normal. He did note that the lungs were heavier than normal and stated that in situations where the heart is totally stopping there may be some back up of blood in the lungs caused by the congestion of the blood vessels. There was also mild brain swelling which could also be caused by cesation of the circulation to the brain with some leakage. It was his subjective assessment that within thirty minutes or so, even during the resuscitation process that this can occur. The usual blood, urine and vitreous humour samples were taken. In particular, Dr. Littman recalls that he took the blood sample from the femoral vein and that it was approximately nineteen hours after Mr. Stevenson had been pronounced dead. The blood chemistry results indicated that there was alcohol in Mr. Stevenson's system and in particular that his blood alcohol was at 112 mg/dl. This was lower than in the urine and than in the vitreous humour which would seem to indicate that by the time he died Mr. Stevenson was in the excretory phase of his alcohol use. As the blood sample was not sent to a forensic laboratory no quantitative analysis was made for marijuana only a qualitive one which indicated that the test was positive for the use of marijuana and that it showed THC or one of its breakdown products indicating that Mr. Stevenson likely had consumed marijuana within the last five days,

although, it was possible that the consumption could have taken place in as long a period as three weeks or more. The blood chemistry results also showed that, as anticipated, Mr. Stevenson had clozapine in his blood. In fact the laboratory results showed that the readings for clozapine were at 1100 ng/ml and noraclosopine was at 580 ng/ml. The usual therapeutic range is between 300 and 700 ng/ml. Dr. Littman was also made aware of the history of restraint used prior to Mr. Stevenson's death and as such his official cause of death on the autopsy report form indicates sudden cardiac death due to or as a consequence of physical restraint due to or as a consequence of elevated blood alcohol and clozapine. Dr. Littman elaborated further in his testimony and indicated that a level of 700 to 1100 ng/ml of clozapine in the blood may not be a huge amount and may not be life threatening. He indicated that after death there is some redistribution of the drug, that it leaches out and that it in and of itself doesn't explain the death of Mr. Stevenson. He further indicated that the post mortem redistribution of clozapine is not well studied and that one has to look at it on a case by case distribution and that there are many factors involved. For instance, that you could get a falsely elevated reading if it was taken close to the stomach and that is why he was careful to take the blood sample from the femoral vein at the top of the leg as far away from the heart as they can take the sample. He candidly acknowledged that he doesn't think that he can extrapolate the level of clozapine accurately and that at best he thinks that they were elevated but he doesn't think they were 50% above the therapeutic level. He comes to this conclusion, because the circumstances demonstrate that Mr. Stevenson was not overly sedated just prior to his death and in fact the exact opposite appears to be the case given the level of excitation and violence that he demonstrated. As such Dr. Littman arrived at the cause of death by exclusion as there is no evidence of cardiac or pulmonary disease etc. His

conclusion was that this was a case of sudden cardiac death which he says is a generic term to conclude that he is just saying that the heart stopped and that he doesn't know what stopped his heart.

Although not explicitly mentioned in his autopsy report Dr. Littman brought up the possibility of what is described as excited delirium or agitated delirium. He indicated that this was known to occur in psychiatric cases including both bipolar, psychotic and patients with schizophrenia. It also is seen in cocaine drug abuse cases. The phenomenon is recognized but poorly understood. Dr. Littman referred the court to a recently published text book by Dr. Dimaio from Texas. He indicated that even this text book is somewhat controversial. Dr. Littman advised that in Ontario they produced a video which was distributed fairly widely to make care givers and police familiar with excited delirium. It appears that this is not a condition which occurs frequently. In fact Dr. Littman said that there are only a handful of these cases that occur in various jurisdictions and that it's not clear what can be done to prevent the outcome in that these occur in very difficult situations where a person has to be restrained but if done then the least amount of restraint possible should be used. In some of these cases nothing can be done. The die is cast seemingly once the delirium starts. Dr. Littman believes that it is a multi-factorial condition with a cascading series of events. Restraint is like the straw that breaks the camel's back. He opines that some of these factors could be: changes in the brain; adrenaline; problems in the heart itself such as a long QT; genetic predispositions; changes in the pH, that is, the acid value in the blood; changes in the heartbeat or changes of carbon dioxide and oxygen in the blood. He

states that even with immediate medical care the outcome may not be any different. This is very much the situation in Peter Stevenson's case.

Dr. Littman indicates that Dr. Pollanen, the Chief Forensic Pathologist in Ontario has written on the subject.

Dr. Littman indicates that many of the prior cases which had been diagnosed as positional asphyxia, for instance the hog tying situations, the impairment of respiration, some twenty years ago have now been disproven. That it's not as simple as that. That there may be some element of restricted breathing but it is not sufficient to explain the deaths.

In this particular situation, given Mr. Stevenson's size, that he was a large man and somewhat overweight, lying on his stomach on the floor, that this affects respiration. Mr. Stevenson would also be rebreathing his own breath which would mean that there would be more carbon dioxide and less oxygen available and that could be just one of the factors.

When examined by Mr. Green, Dr. Littman candidly stated that excited delirium may have caused Mr. Stevenson's death and that it cannot be projected readily in advance because it is many faceted. He also indicated that in many of the cases of excited delirium a restrained person may have unusual strength, that they would fight like everything and there would be tranquility and then cardiac arrest. Dr. Littman agreed that that seemed like the scenario that took place in regards to Mr. Stevenson. When questioned by Mr. Kochanski, Dr. Littman concurred that one of the factors is an episode of delirium or agitation and restraint but he

also said that death due to agitated delirium can on occasions occur even without physical restraint and that the exact body chemistry is not understood.

Part II of the autopsy report lists other significant conditions contributing to the death but not causally related to the immediate cause. When asked to explain the inclusion thereunder of alcohol and clozapine in the blood of Mr. Stevenson, Dr. Littman clearly indicated that these are things that may have contributed to his death and if they did he is not sure to what extent if any they contributed to the death. He stated that they are risk factors and in particular that when dealing with alcohol and clozapine that they are significant findings that may have had a causal effect; that there is no right or wrong answers to what part alcohol or clozapine may have played. Dr. Littman acknowledged that in his autopsy the heart muscle showed no abnormalities with the naked eye and that only a portion was examined with a light microscope. He agreed that maybe at the molecular level, for example a long QT interval, that that might be a factor. There may have been something that they couldn't find. When further questioned about clozapine levels, Dr. Littman indicated that there have been cases when the post mortem levels of clozapine can be three times higher than the anti mortem levels and he reconfirmed that he did not view the levels of clozapine to be life threatening. When questioned by Ms. Hoeppner on the issue of what role alcohol had to play, Dr. Littman indicated that that was hard to say. When questioned by Mr. Head, Dr. Littman indicated that there have been some cardiac deaths associated with the use of clozapine and that this is found in the information supplied by the drug manufacturer. He also indicated that many of the anti psychotic drugs are associated with sudden cardiac death as are some illegal drugs. He summarized by saying, "I can't point to one factor to say why his heart stopped; excited or agitated delirium is not a specific condition it is more a description of a symptom

complex". It was Dr. Littman's testimony that agitated delirium has been well recognized although the actual physiological path is not known. He stated that some people believe that if it occurs, it inevitably leads to death; some people believe that asphyxia plays a larger part; some people believe that it is multi factoral and some people believe that it can be treated, others not. He felt that on this report you could substitute the term "sudden cardiac death" with excited delirium.

During the course of his testimony Dr. Littman brought to the court's attention an article entitled *Excited Delirium and its correlation to sudden and unexpected deaths proximal to restraint, a review of the current and relevant medical literature* by Sgt. Darren Laur with the Victoria Police Department which was published during the month of November, 2004 two months after Mr. Stevenson's death. The article makes interesting reading for those who may have to deal with any individual who may be suffering from excited delirium such as police officers, security personnel, those that deal with psychiatric patients and the like. It does not provide any new research but rather is an investigation of other cases and articles which have been written on the subject. The article was very helpful in describing, firstly, the presenting body on enomics related to excited delirium and, secondly, in listing the contributing factors. At page 17 of this paper Sgt. Laur indicates the common outward signs of excited delirium and he indicates the same are as follows:

1. unbelievable strength
2. impervious to pain
3. able to offer effective resistance against multiple officers over an extended period of time (one case in Calgary, Alberta, Canada, multiple officers wrestled with a person that was suffering an excited delirium for over 15 minutes)
4. overheating
5. sweating
6. bizarre and violent behaviour

7. aggression
8. hyper activity
9. extreme paranoia
10. incoherent shouting.

In the case of Mr. Stevenson there was evidence of strength beyond normal, there was evidence that he was able to offer resistance to four to six persons for a period in excess of 10 minutes. His conduct before and during the incident was certainly bizarre and violent. He displayed aggression toward Mr. Pommer. He appeared to have been shouting at the time using vulgarities although there was no evidence that he was incoherent. We know that by virtue of his disease he also suffered from paranoia.

The paper then goes on to describe the contributing factors, some of which are not applicable to Mr. Stevenson, as there was no evidence of cocaine use. As a contributing factor number 4 he mentions metabolic acidosis. The low pH level in Mr. Stevenson's blood would seem to indicate that he was, in fact, suffering from metabolic acidosis. The article states as follows:

> "Due to the fact that the literature reports that delirium, both by psychosis or drug, may alter pain sensation, it allows for physical exertion far beyond normal physiological limits and may result in a severe acidosis with maximal sympathetic discharge."

His paper also has as contributing factor number 6, anti-psychotic drugs and sudden death. The paper also refers to face-down, prone restraint proximal to the arrest and states that in the majority but not all of sudden and unexpected deaths proximal to restraint involving a subject experiencing excited delirium that most subjects had been restrained and left in a prone position. The paper goes on to state:

> "Although Dr. Ray's research on specific positional asphyxia, has been put into question by Chan, Snowden and Ross's independent research, remember

> that Dr. Chan's research has been medically questioned and challenged as well. (There still appears to be some medical and physiological issues with restraining a subject who is experiencing excited delirium for an extended period of time in a prone position.)
>
> "One keystone that was identified and that appears periodically in the medical literature surrounding excited delirium, is dangerous lowering your pH. If blood pH drops too low then death, attributed to cardiac arrest is a certainly if pH is not corrected (Ortega-Carnieer, Berthos-Polo and Gutierrez-Tirado, 2001). Some medical literature reviewed for this paper points to the fact that pH can be affected either metabolically through acidosis, very common in excited delirium, or through hypo ventilation, a state in which a reduced amount of air enters the alveoli in the lungs resulting in decreased levels of oxygen and increased levels of carbon dioxide in the blood. Causation of hypo ventilation can be due to breathing that is too shallow, hypopnoea or too slow bradypnea or too diminished lung function…"
>
> "Because we know that body position affects control or breathing in exercise by altering the coupling between ventilation and pulmonary gas exchange, is it possible that the prone restraint interferes with this fundamental tenant of blood, gas, homeostasis for those in an excited delirium state who are kept in a face-down prone position? In discussions with Dr. Christine Halk, program director at FRC program in emergency medicine during a seminar on excited delirium hosted by the Calgary Police Department she hypothesized that hypo ventilation may be contributing to a fatal shift in blood pH. In her hypothesis, individuals suffering from excited delirium who are restrained in a prone position may be unable to breathe rapidly enough to exchange carbon dioxide. Although these individuals have a clear airway and can speak their restraint prevents them from breathing at a rate necessary and the excess carbon dioxide contributes to an acidonic state."

Sgt. Laur then refers to some case studies and in the case studies that the respective pH's of the person presumed to have had excited delirium were as follows: case 1. pH 6.46 case 2. pH 6.81 case 3. pH less than 6.8 case 4. pH less than 6 case 5. pH 6.25. When we compare that to the results of the arterial blood gas taken in Mr. Stevenson we see that his pH of 6.852 is within the range of those who suffered from the excited delirium in the case studies.

Given the comments of Dr. Littman and the similarities between the circumstances surrounding Mr. Stevenson's death and that of the case studies outlined in Sgt. Darren Laur's report I can conclude that Mr. Stevenson probably died from what is referred to as agitated delirium. This particular cause of death has been referred to in several other inquests conducted in recent years in Canada. One of the most recent examples of such is an inquest conducted by my brother Judge Joyal with the report released on the 11th day of July, 2005. It involved two separate deaths; that of Lauri Lee Draper who died on February 23, 2002 and Arthur Randy Gill who died on February 10, 2002. Both of those deaths had been attributed to excited delirium and in both of those deaths as well there had been a prolonged use of cocaine although not necessarily of an extremely high concentration at the time of death. The use of cocaine certainly distinguished that report from the situation involving Mr. Stevenson to a certain extent. In the case of Lauri Lee Draper she had gone into a home which caused the residents concern and even fear. Those residents were, in fact, confronted by a woman at their front door who was described as hysterical, paranoid and out of control. Not surprisingly they called the police. When the police arrived, because of prior training, they quickly recognized that this was a case they suspected of excited delirium. Froth was seen coming from the sides of Ms. Draper's mouth, she was incomprehensible and appeared to be non-comprehending. She was handcuffed. Notwithstanding same she continued to resist and she was described by one of the witnesses in that case as "like a rabid animal". Reluctantly she was placed in the prone position for a period of time without applying any weight or pressure upon her upper torso. The ambulance was called and once the handcuffs were removed the distress started to intensify. All of those on the scene agreed that it was necessary to restrain Ms. Draper. Notwithstanding the early identification of the excited

delirium, her condition deteriorated while on route in the ambulance. They attempted to ventilate her but there was no palpable pulse or respiratory effect and notwithstanding the administration of Epinepheram and Narkam the heart rate remained extremely light and on the whole she remained unresponsive. She died shortly after in the hospital.

The factual circumstances involving Arthur Randy Gill were that the first officers on the scene responded to a call about a very large man half undressed screaming and standing in the middle of Arlington Street while bleeding from his arm. Mr. Gill eventually became very resistant and violent. He turned to yell in a somewhat paranoid fashion and the intention throughout was to have Mr. Gill attend at the hospital. In Mr. Gill's case even though there was no formal identification or a diagnosis of excited delirium at the scene it seems clear that everyone recognized that this was a medical situation and there was additional caution and care in how the police and paramedics dealt with what was Mr. Gill's bizarre behaviour. This is how Mr. Gill's behaviour at the scene was described in Judge Joyal's report,

> "Because of his very large size and his powerful strength the ambulance attendants required the assistance of five or six other's to get him onto the stretcher. While attempting to pull Mr. Gill on the stretcher, he continued to thrash about, spit at the paramedics and generally twist and turn. As a result of his struggling he kicked out and hit one of the ambulance attendants in the head. It quickly became clear that it would not be possible to keep Mr. Gill on the gurney. Mr. Gill soon rolled off the gurney onto the street (on his stomach) where he continued to kick and thrash about. Despite everyone's verbal attempts to reason with Mr. Gill and to generally calm him down, his aggressive struggling continued. ….Accordingly the police attempts at restraint required keeping Mr. Gill on his stomach while various officers placed there feet gently on other parts of his body. …No real pressure was placed on Mr. Gill's back or head. Nothing was done to block his airways or respiration. While awaiting for shackles for Mr. Gill he was kept on his stomach during which time he continued his erratic and violent struggling. Mr. Gill remained on his stomach even on the stretcher in shackles and after he was placed in the ambulance it was then that they noticed the first signs of obvious distress, that is, that Mr. Gill was no longer breathing or breathing inadequately. Mr. Gill was unshackled and the emergency treatment began. Despite aggressive resuscitation measures initiated by the

> paramedics Mr. Gill did not regain a pulse at the scene or on route to the Health Science Centre."

As can be seen there are great similarities between the death of Lauri Lee Draper, Arthur Randy Gill and of Mr. Stevenson in this case. Judge Joyal had the benefit of hearing from Dr. Polatnick at his inquest and Dr. Polatnick suggested that there are four particularly important points that need to be remembered when dealing with any case of excitable delirium. They are the following:

> "1.) protect the person, yourself and others while not agitating that person unnecessarily; 2.) to the extent possible (and Dr. Polatnick stressed that it is not always possible) use minimal restraint. 3.) so as to prevent compromising the diaphragm, when attending to or attempting to restrain a person suffering from excitable delirium, it is important to avoid the prone position (placing the individual on his or her stomach). 4.) attempt to avoid any general pressure on the airways."

That would be the ideal and Dr. Polatnick went on to indicate that it is not always possible to follow this because individuals who present as agitated, aggressive and generally out of control because of the increased adrenalin can exhibit uncharacteristic strength. That usually necessitates a level of force and restraint irreconcilable with the care ideally required.

It appears that the City of Winnipeg Police Department have taken the issue of excited delirium extremely seriously and have, in fact, prepared a policy to deal with same. That policy is accompanied by a video that all City of Winnipeg police officers were required to view.

Judge Joyal made only two recommendations as a result of the death in question. They are certainly worth repeating. His recommendations are as follows:

> "Recommendation No. 1: While always a difficult diagnosis to make when it comes to emergency responders (police, first responders and paramedics) there is a continuing need for the most comprehensive distribution possible concerning information about excitable delirium. Such information may come from existing training manuals, videos and more formal policies. All the emergency services must remain diligent to ensure that in this regard, their policies and training manuals are kept up to date and regularly monitored by employees."
>
> "Recommendation No. 2: That the issue of police response in restraining cases of excitable delirium be made a subject for future police training sessions relating to 'use of force'."

During the course of their testimony at this inquest those who were involved in the restraint were asked about their knowledge of excited or agitated delirium. From Dr. Warraich, the emergency room physician, through the emergency room nurses, to the paramedics and the R.C.M.P., none had sufficient working knowledge to be able to deal with this situation. For instance, when Dr. Warraich was asked about excited delirium his comment was that, "this is a psychiatric job, I don't know that term". When asked about the symptoms he said, "I have heard of the phenomenon of people getting excited then dying" but went on to state that, "I haven't seen such a case, I have been practicing here for 15 years and I never seen a case such as this". When staff Sgt. David Mancini was testifying he indicated that at the time of Mr. Stevenson's death excited delirium was not known to him. Their policy would have been to call E.M.S. paramedics and to bring the subject to the hospital. Since then, while awaiting a national policy on excited delirium, "D" Division in Manitoba has instituted an interim policy which is there to bring to the R.C.M.P. members' attention that this phenomenon exists. Apparently it was Mr. Stevenson's death that prompted the amendment to the policy. The particular policies are to be found in part 19.2 "Accessing responsiveness/medical assistance". Of particular importance, are the following subsections:

> "1.2 positional asphyxia occurs when a person is restrained in such a manner that their heart and lung functions are compromised resulting in a lack of oxygen in their blood.
> 1.2.1. restraining a suspect in a prone position must be avoided in order to prevent death or injury by positional asphyxia.
> 2. Medical Assistance
> 2.1. in addition to the situations noted in national headquarters directive 19.2, immediate medical assistance must be obtained for individuals who are in custody and appear to be chemically dependant or displaying effects of excited delirium.
> 2.1.4. excited delirium is a medical phenomenon associated with individuals who suffer psychological illness, chronic illicit substance abuse, or a combination of mental illness and substance abuse.
> 2.1.4.1. suspects in a state of excited delirium have exhibited unusual bursts of physical strength followed by unresponsiveness and eventual cardiac arrest and death after they have been subdued. Symptoms of excited delirium may include; unbelievable strength and endurance, inability to feel pain, overheating, sweating, bizarre and violent behaviour, aggression, hyper activity, extreme paranoia, and incoherent shouting.
> 2.1.5.encourage the examining physician to admit the prisoner as a patient or arrange intermittent monitoring by a medically trained person (if placed in cells).
> 2.2.2. medical treatment must be provided immediately.

In comparison to this policy, Judge Joyal comments on the City of Winnipeg Police's response in policy to situations involving excited delirium. He says the following:

> "The earlier mentioned policy and video provide instruction on how to recognize excitable delirium and how best to respond in ways to ensure not only the safety of the suspects and bystanders but also the safety of the police officers themselves. The instructions assume that police officers are dealing with individuals who are potentially very aggressive, paranoid and suddenly in possession of uncharacteristic strength. Accordingly, the policy and video are just immediate attempts to reason and calm the suspects. The inevitable restraint required must be performed with moderation. All efforts should be made to ensure that there is no weight placed upon the suspect's torso and where possible officers should avoid the prone position. Ideally, the suspect should be sitting up. Once in a position to be monitored, the vital signs should be verified as soon as possible (airways, breathing and pulse)."

Judge Joyal goes on to state that staff Sgt. Bishop of the City of Winnipeg Police asserted confidently that either because of roll call or instruction at the academy all new and veteran

members of the Winnipeg Police Service should now be aware of the 1998 policy concerning excitable delirium.

I strongly echo Judge Joyal's two recommendations. Furthermore I would extend his list to not only include police, first responders and paramedics but also to include emergency room doctors and nurses as well as psychiatric ward nurses and aids. And that all of these individuals receive future training sessions relating to excited delirium and the use of force in those cases. I would also encourage that the City of Winnipeg Police policy and video be studied by those in charge of policy at the R.C.M.P. to see if it may be of assistance in improving their current policy.

During March of 1989 Judge Minuk authored a report pursuant to the Fatality Inquiries Act arising in respect of the death of Georgio Joseph Ciampini. Interestingly enough Dr. Littman was also the pathologist who did the autopsy on Mr. Ciampini. Dr. Markesteyn also attended that autopsy. It was found that Mr. Ciampini had ingested cocaine. His death occurred on September 23, 1988. Police officers saw him walking on Ellice Avenue and observed him acting in a strange manner. He was shouting unintelligibly and the police went to investigate. At first the deceased was amiable and friendly to the officers and in fact gave an affectionate bear hug to one shouting, "I love you, I love you". The police tried to humour the deceased, however, he refused to let go of his hold and tightened his grip and both officers attempted to restrain Mr. Ciampini who was by now becoming agitated and belligerent and exhibiting unexpected strength so much so that the officers had difficulty restraining him. After a brief struggle he was forced to the ground and they held him face

down while he continued to thrash about. Later two other police officers saw what was happening and went to assist. While the victim was being held down handcuffs were placed on his wrists and there were also cuffs placed on his ankles. While he was being held on the ground the officers noted that he had become very still and on closer examination they discovered that he had stopped breathing. Again these are circumstances that are quite similar to those of Mr. Stevenson. During the hearing of the evidence Dr. Markesteyn alluded to an article entitled, "Cocaine induced psychosis and sudden death in recreational cocaine users" cited at page 6 of Judge Minuk's report. That article was published in the July 1985 edition of the Journal of Forensic Sciences. The conclusion reached in that article was quoted by Judge Minuk and stated the following:

> "Police and emergency paramedical personnel should be aware of the potential for sudden death in association with excited delirium. As such there should be no delay in transporting such patients to a nearby medical facility and the cardio respiratory status should be constantly observed. Should cocaine be considered a possible cause of the excited delirium, emergency room physicians should be prepared to provide appropriate medication for sedation and control of sympathomimetic symptoms and provide adequate ventilatory support. It is hoped that prompt diagnosis may prevent sudden respiratory collapse and death in these recreational cocaine users."

Judge Minuk focused on the cocaine intoxication and recommended training for police officers and those personnel and others charged with the responsibly of protecting the public.

Judge Lismer also conducted an inquest into the death of Robert Leuthard and filed his report on the 20th of April, 1993. Mr. Leuthard died on the 8th of November, 1992. Again this was a situation where he had been ingesting cocaine. The deceased had registered at a motel, told the desk clerk that he had been driving for 24 hours and was seeing things that weren't there like lights flashing and he was hallucinating. About 25 minutes later while in his room he

began yelling and screaming and banging around on the second floor of the motel. The clerk called and sought assistance from the City of Winnipeg Police Department. The police, based on comments made by the deceased, concluded he was freebasing cocaine and when the deceased began running up and down the hallway yelling, "you guys aren't cops you're setting me up," the police resolved to restrain him. They took a hold of the subject and laid him on the floor face down in an attempt to handcuff him with his hands behind his back. All the while he was physically struggling and resisting very forcefully when suddenly he became limp and all vital signs disappeared. Prompt resuscitation attempts by the police officers at the scene and thereafter by members of the fire department, ambulance crew and finally by the medical staff at the St. Boniface General Hospital were all unsuccessful. Once again the autopsy disclosed no anatomic cause of death. The amount of cocaine was very elevated and the toxicologist believed that it was responsible for the death in question. The toxicologist's report was quoted by Judge Lismer as follows:

> "There have been a number of reports of recreational cocaine users who die suddenly and unexpectedly after cocaine use, but who initially present with an excited delirium. Symptoms begin with intense paranoia, followed by bizarre and violent behaviour necessitating forcible restraint. The user may exhibit unexpected strength and hyperthermia. Fatal respiratory collapse occurs suddenly and without warning, generally within a few minutes to an hour after the victim is restrained."

Judge Lismer made no recommendations.

It appears to be the case that the situations involving excitable delirium resulting in death are not a common occurrence and in fact may be quite rare. But they do occur even in Manitoba as shown by these prior inquest reports.

In Ontario as well there have been cases where the cause of death has been attributed to excited delirium. One in particular, the death of Nicolas Blentzas on June 23, 2002 at the Toronto East General Hospital, is similar in that it does not appear to have involved the use of cocaine or any illegal drugs by the deceased. Police were called when they received a report of a man striking a door with a fire extinguisher. They arrived to find the deceased throwing himself against his apartment door. He told the police that he was being treated for a psychiatric illness and agreed to accompany them to hospital for an assessment. He initially went voluntarily with the officers but ran away when the doors opened in the lobby. The police officers gave chase and caught up to him across the street where they attempted to restrain him physically and with pepper spray in order to arrest him under the Mental Health Act. An ambulance was called and paramedics arrived to find him lying on the ground with no vital signs. Resuscitation efforts were unsuccessful and he was pronounced dead at the hospital. Unfortunately, in Ontario a jury renders the decision and recommendations after the inquest and we only have the notes of the coroner but these notes are quite informative. They are as follows:

> "The jury heard evidence that individuals with excited delirium exhibit hallucinations and violent behavior, and may need to be restrained by police officers to permit transportation to hospital for psychiatric care. However, restraint in the prone position may increase their risk of sudden death. This recommendation is intended to promote education of police officers about excited delirium to assist them to recognize that they must avoid prolonged restraint in the prone position if possible and arrange for emergency medical treatment.

In that case the jury's recommendations dealt specifically with training.

Instances of death through excited delirium for people who suffer from psychiatric disorders and who are on medication for same is not restricted to adults. The inquest into the death of

William Edgar who died on March 31, 1999 is indicative of that. In fact there have been many inquests across the country for people who have died in similar circumstances to those of Mr. Stevenson. Many with similar recommendations for training to recognize the same symptoms of excited delirium and the roll especially that restraint in the prone position seems to play. These deaths, though infrequent as they are, do occur and there should be a greater awareness possessed by those who are in circumstances where they have to deal with those individuals who are at risk of suffering from excited delirium.

Mr. Stevenson's Psychiatric Condition and the use of Clozapine to try and control his symptomology

Because Dr. Littman listed clozapine as another significant condition contributing to the death but not causally related to the immediate cause it is important to consider its use upon Mr. Stevenson. Mr. Stevenson was under the care of a psychiatrist in The Pas, that being Dr. Thomas Medd. Dr. Medd obtained his MD in 1982 and practiced for 12 years as a family physician primarily with First Nation's and Inuit health and also in Dauphin, Manitoba. He then completed a 4-year residency at the University of Manitoba in December of 1997. He started his work as a psychiatrist as the Selkirk Mental Health Centre. Around the year 2000 he moved to The Pas and he has been working for the Norman Acute Care Psychiatric ward since. The majority of his work deals with out patient consultations and he also is an itinerant psychiatrist in Shamattawa. In describing the nature of his practice in The Pas he was of the opinion that he tended to follow more people with significant problems such as bi-polar, schizophrenia and anxiety disorders than might be the case if he was practicing elsewhere. Dealing with the psychiatric ward in The Pas, he indicated that there were

probably about 150 admissions a year to the unit with 30% suffering from schizophrenia. Dr. Medd was treating Peter Stevenson for chronic paranoid schizophrenia. Peter had previously attended the Brandon and Selkirk mental health facilities in the years 1999 and 2000 and Dr. Medd had the opportunity of reviewing the previous discharge summaries and the files from community mental health. At that time it was clear that Peter was suffering from some form of psychosis but it was Dr. Medd who made the diagnosis of schizophrenia. Dr. Medd described some of Peter's psychotic symptoms as; he felt he was being stalked and he had concerns of sexual assault in his room, which were truly not the case; he thought that a cat was making him follow it to other areas and that he could communicate with the cat in some fashion; he thought he could communicate telepathically with pregnant women and he felt that he could read people's minds or that others could read his mind. Although Peter denied any auditory hallucinations he was often muttering to himself, sometimes having a full scale conversation with himself. He also had delusions that from time to time that he was an arch angel and that he could hear heaven. He recalled that Peter had 3 possibly 4 prior admissions to his psychiatric ward and that he would see him in follow up once or twice after discharge then Peter would drift away. Peter's attendance at community mental health was even more erratic. He was also aware of the fact that Peter had been diagnosed as F.A.S.D. and that this diagnosis had been made by Dr. Chudley when Peter was much younger. The symptoms were recognized and were obvious insofar as the schizophrenia was concerned and because they persisted over time, he made the diagnosis. The fact that Peter suffered from Fetal Alcohol Spectrum Disorder was important information to know as this could affect Peter's impulsivity and quickness to anger and it did affect his attention, his memory, his executive functioning, the fluency of thought and social cognition. Dr. Medd was of the opinion that

the schizophrenia would even trump this and would make all of these things worse in all areas.

Dr. Medd also described that Peter had this delusion about $5,000.00 and an inheritance of some type and that Peter was convinced that the Royal Canadian Mounted Police now had the money or at times that they didn't find the lost money. He made a lot of visits to the R.C.M.P. and they were very patient but at times Peter was under the delusion that the R.C.M.P. wanted to kill him. On one occasion Peter had indicated that he was relieved that he had seen a certain female R.C.M.P. officer and he said that he believed the police thought that he had killed her. Accordingly, it would be very unpredictable what Peter could do in a situation where the police would come to get him. Peter also talked about voices bothering him. Dr. Medd thought when Peter was last admitted that he was in significant risk of further deterioration if not treated. In the past Peter would change his mind about wanting to stay or wanting to leave and that this presented a problem in treatment. As such Peter was admitted as an involuntary patient in order to ensure that the course of treatment would be completed. Dr. Medd had tried various medications to assist Mr. Stevenson. In particular Peter had been on Olazapine for a year or so and although there was some significant improvement it was not an optimal response. He was not as agitated but he was still delusional. On his admission in February of 2004 Dr. Medd switched his medication to Rispirodon, it's a second generation anti-psychotic, and eventually Peter reached a top limit and this was continued until his final admission in June. There was some issue as to whether or not Peter was being compliant with the taking of his medication. The issue of attempting a clozapine treatment with Peter was raised but as this required regular blood tests and a need for

needles, Peter was resistant to the idea. Peter did not like needles. As such Dr. Medd then attempted Quetiapine and it was pushed higher but it was not the adequate response as well. Clozapine is a drug that has been used by psychiatrists for a significant period of time. For a period of time, because of its extremely dangerous potentially fatal side effects, it was removed from the market. But clozapine is apparently a very effective anti-psychotic drug and it was reintroduced provided that there was stringent monitoring. Dr. Medd advised that he went over the side effects of clozapine with Peter and Peter signed a consent to use the drug clozapine. The most dangerous side effect from the use of clozapine could be agranulocytosis which is the body not making any further white blood cells leading to a high risk of infection and death. Apparently this condition is completely reversible by the cesation of the use of clozapine. Accordingly Mr. Stevenson's white blood count had to be monitored at least weekly in order to have the medication administered to him. The compendium of Pharmaceuticals and Specialties, The Canadian Drug Reference for Health Professionals published annually by the Canadian Pharmacists Association for the year 2003 sets out some of these possible side effects. The following cautionary paragraph is of interest.

> "A minority of clozapine treated patients experience ECG repolarization changes similar to those seen with other anti-psychotic drugs, including S-T segment depression and flattening or inversion of T waves. There have also been reports of ischemic changes, myocardio infarction, non fatal arrhythmias, sudden unexplained deaths and congestive heart failure in association with clozapine use. Causally assessment was difficult in many of these cases due to serious pre-existing cardiac disease and possible alternative causes. Rare instances of sudden unexplained death have been reported in psychiatric patients with or without associated anti-psychotic drug treatment and the relationship with these events to anti-psychotic drug use is unknown."

There is also the warning that clozapine may enhance the central effects of alcohol.

Dr. Medd was aware of the risks associated with clozapine and very carefully titrated Mr. Stevenson's dose over a period of time and carefully monitored him for possible side effects including the weekly blood tests for agranulocytosis. Peter's symptoms appeared to be improving while he was being treated with clozapine, so much so that a discharge plan was in the works and it was anticipated that Peter would have been discharged within a week or two. While listening to his testimony, Dr. Medd struck me as a kind, caring and sympathetic individual who was deeply troubled by the loss of his patient. A review of the hospital charts shows that Peter had not been given any more medication than was appropriate pursuant to the usual guidelines. In fact it had been some twenty two hours or so since his last regular night time dosage of clozapine. He was receiving 500 mg per day and the maximum dosage as suggested by manufacturer is up to 900 mg per day.

Dr. Yaren, a psychiatrist who has previously been qualified to testify in courts on many occasions provided the court with a report wherein he completely endorses the treatment that Dr. Medd was administering to Mr. Stevenson including the use of clozapine in his particular situation. Dr. Medd had been provided with and read copies of Dr. Yaren's report and concurred with same. He also received the report from Mr. Thurmeier, the pharmacist specializing in psychiatric drugs and he also concurred with the conclusions reached by Mr. Thurmeier who also did not see anything inappropriate in the use of clozapine and the dosage that was being administered to Mr. Stevenson.

Surprisingly, Dr. Medd had not heard of the term agitated delirium before but he had read Sgt. Laur's paper prior to testifying and he stated that he did have some difficulties with

some of the concepts expressed in the article. As a physician Dr. Medd had tried to ascertain the cause of death and had his own thoughts. He felt that there were a few factors involved here. He thought that there was a great deal of agitation and there was the restraint. The agitation would affect the adrenal cortex causing catacholamines to pour out which can excite the myocardium and affect any pre-dispositions that the patient may have. He also felt that alcohol being a depressant may have contributed to his ability to appreciate the degree of pain he was in and contributed to an exertion therefore beyond normal limits. This would result in combination with the restraints to an acidosis that being that the carbon dioxide was not being expelled at a sufficient rate. It was a combination of those factors he felt that lead to Mr. Stevenson's death. Many of those factors are part of that cascading series of events previously identified by Dr. Littman leading to a sudden cardiac death now being referred to by many as excited delirium.

Dr. Medd clearly felt that clozapine is one of the most effective drugs for the treating of schizophrenia and he thought it unlikely that clozapine was a factor in Mr. Stevenson's death. He stated that since Peter's death he's had numerous discussions with some of the top psychiatrists in the American Psychiatric Association and with those who are the most expert in the field. He also was of the opinion that blood serum levels are not necessarily a factor. It is his opinion that he can titrate clozapine which means that he can slowly increase it in patients until you get the desired effect. He has done blood serum testing on some patients, although not on Peter Stevenson and in order for clozapine to be effective there has to be a minimum of 400 ng in the blood serum. He has also had situations where he has found clozapine in blood serum levels in patients of over 2,000 ng. That would be in patients who

have a severe illness and were not responding to the lower dosage. The clozapine levels found in Mr. Stevenson's blood taken by Dr. Littman 19 hours after his death were at 1100 ng/ml. The lab indicated that the therapy ranges should be 300 to 700 ng/ml. There was also narclozapine found in the blood at a concentration of 580 ng/ml. Narclozapine is a breakdown product of the drug clozapine. Although both Dr. Medd and Dr. Yaren in his letter indicated that there is an increase in the blood serum levels after death, it was Mr. Thurmeier the pharmacist who provided the best evidence on this point.

Richard Thurmeier

Richard Thurmeier is the senior pharmacist and mental health liaison person at the St. Boniface Hospital in Winnipeg. Psychiatric medicine is his area of expertise. It is his role to interact with medical students on the ward level on a day to day basis. In addition he is an associate professor at the University of Manitoba teaching psychiatric medicine at the School of Pharmacy. This is a part-time roll encompassing approximately 7 ½ hours per week during the school term. He also has many years of experience with the use of clozapine, as he is the care coordinator for patients taking clozapine, officially doing so for 4 years and unofficially even longer before that. Mr. Thurmeier also had an opportunity to review Mr. Stevenson's hospital records. Mr. Thurmeier indicated that the usual dosages are between 300 to 450 grams per day but that this could be higher for individuals that are male, who are overweight, under 40 and are smokers. It should be noted that all of these factors were present in Mr. Stevenson's case and that accordingly he may have required a bit higher dose. Mr. Thurmeier also indicated that the longer a person has been ill the higher the required dose to maintain the same therapeutic response but that is very variable and done on an

individual patient basis. He was of the opinion that the strategy employed by Dr. Medd was consistent and within the treatment guidelines and practices. Mr. Thurmeier also indicated that trying to correlate the serum level, even in a patient who is alive, to the dosage received is a tenuous thing to do because there are a lot of individual variations between patients. Different people have different absorption rates of between 50 and 60 percent. Different people have different rates of metabolism as the drug metabolizes in the liver and factors such as smoking have an affect on liver enzymes that cause the drug to metabolize even faster. A certain portion of the drug will migrate to the fatty tissues of an individual. We were told that one of the side effects of clozapine is an increase in an individual's weight. The more weight one has the more clozapine can be stored in those fatty tissues. As such the conclusion is that blood serum levels don't necessarily tell us the dose that the patient was receiving. He also indicated that in general those who consume alcohol at a higher level have a liver that functions at a higher level and this too would cause clozapine to metabolize more quickly. Mr. Thurmeier indicated that the monitoring of the blood serum level is not really useful for therapeutic purposes as many side effects don't correlate with the serum level and the effectiveness of the drug upon various individuals does not necessarily correlate to the blood serum level. The testing is costly and not usually worth it. The situations where they would be monitoring the blood serum level is where you're not sure if the patient is properly taking the medications or if he's not responding as anticipated. In his experience probably only 1 in 20 patients would have these blood serums done and that the data is for their chart only and not shared with the profession generally. This explains why Peter's blood serum level was not being monitored. It is difficult to know what his blood serum level was immediately prior to his death as clozapine is subject to post mortem redistribution.

Clozapine is highly fat soluble and poorly water soluble. As such it will bind to plasma proteins and within the fatty cells of tissues and organs. Therefore the amount of drugs stored in the body may be increasing. These would not be reflected in the blood serum while the person is still alive. When a person dies there are pH changes and other factors that occur at the time of death and this causes some of these previously stored drugs to be re-released into the serum. The amount of this post mortem redistribution is not known at this time with any degree of precision but it can be quite significant. Mr. Thurmeier indicated that if clozapine is stopped in regards to a particular patient you'd have to continue monitoring it over time for a period of at least 4 weeks as the clozapine continues to leach into the system from the fatty cells. He described it as more of a dumping phenomenon after death but the degree of this dumping is quite variable from individual to individual and that there simply has not been enough science on it. As such, he testified that the post mortem level does neither support nor rule out excessive clozapine levels anti mortem. He was of the opinion that the symptoms of the patient prior to death would be more valuable in determining whether or not there were high blood serum levels. He states that clozapine tends to be quite sedating and that when someone stands up their blood pressure goes low. He surmised that if the amount of clozapine that was found post mortem was actually in the blood serum when Mr. Stevenson was alive that we would expect to see drowsiness, a walking gait that was disturbed, that he would look a little inebriated, that he would have difficulty urinating, and that he would have a very dry mouth and eyes. Those were not the symptoms we saw in a very agitated Mr. Stevenson prior to his death.

Prior to testifying Mr. Thurmeier wrote the drug companies and sought information about sudden death in clozapine. In his own practice he has in fact seen one patient with a sudden unexplained death but that patient was a female taking lanzopine which is a similar drug to clozapine.

Mr. Thurmeier made it clear that "It behooves all of us in health care that these catastrophic side effects are reported." It should be the physician who takes that roll and he would include death or heart attack as is being such a catastrophic side effect. When asked about this Dr. Medd did in fact indicate that he had reported this tragic event to Health Canada.

In response to the letter he wrote to the drug companies Mr. Thurmeier did get a response from Novartis. It seemed to indicate that the numbers were relatively low but yet higher than he was comfortable with. He thinks that it will now affect his practice. Despite the fact that there is no evidence that we can detect things that will prevent these types of events, he was of the opinion that more intensive monitoring, especially with E.K.G.'s, might help. He would look to changes in the QT intervals and even if it shows a minor change in the functioning of the heart it could show some degree of cardio miopathy, that is that the heart is not functioning as well. Other things to look for would be the patient being out of breath and fatiguing more easily. Mr. Thurmeier stated that he couldn't help but wonder if more monitoring could save lives. Mr. Thurmeier was familiar with excited or agitated delirium. He stated that he couldn't say how often it occurs and that it was open to conjecture, especially as to how often it occurred in psychiatric patients.

From a chemical stand point he indicated that there was no relationship whatsoever between cocaine and the anti-psychotic drugs. In fact they do the opposite things. Notwithstanding these concerns that he had, Mr. Thurmeier was still of the opinion that Mr. Stevenson's death could not reasonably have been anticipated in these circumstances. When Mr. Thurmeier was asked what effect clozapine would have if it was in the fatty tissues of the body, his response was that the drug has a sight of action which is within the brain and therefore it would be completely dormant when the drug was in storage in the fatty tissues and have no effect. When questioned by Mr. Kochanski, Mr. Thurmeier acknowledged that we all have a risk of sudden cardiac death but that patients with schizophrenia have a higher risk and that patients who are on clozapine have an even higher risk yet. He candidly acknowledged that the relationship is unknown and yet to be determined. At one point Mr. Thurmeier even said that the whole excited delirium issue kind of baffles him and that they see patients demonstrate the signs of agitation in the E.R. everyday but the excited delirium leading to sudden cardiac death doesn't happen very often.

Based on Mr. Thurmeier's testimony I am unable to determine what the blood serum level of clozapine was anti mortem. It may have been somewhat elevated but that itself would not account necessarily for Mr. Stevenson's death. The evidence is such that I can only conclude as did Dr. Littman that clozapine possibly may have been a contributing factor in Mr. Stevenson's death. Clearly more research and study has to be done in this area or, as Dr. Littman hoped for, that some day there would be an anti psychotic drug as effective as clozapine and without all of the negative side effects.

Mr. Stevenson and his diagnosis of Fetal Alcohol Syndrome

Peter Stevenson was diagnosed in 1995 by Dr. Chudley with full blown Fetal Alcohol Syndrome. This is a permanent condition caused by brain damage by reason of alcohol being consumed by the mother while the fetus is in utero. It is irreversible. However, many secondary affects can be alleviated by education and many problems can be minimized if the affected person's caregivers are aware of the individual's shortcomings and respond appropriately. This diagnosis was obtained because Mr. Stevenson had been a child in the care of Child and Family Services. The information was also shared with the Department of Family Services and Housing, Support Living Program and Services for Persons with Disabilities Division. Their files contain a wealth of information as to how F.A.S. had affected Peter and his behaviour. His situation was very well know to the extent that John Scott, the Regional Programs Manager for Manitoba Family Services Norman Region on November 24, 1998 attempted to intercede on Peter's behalf to get him into the Salvation Army Community Residential Services Program. By example of the problems Peter was perceived to have faced Mr. Scott wrote the following: "He is easily imposed upon by others, has difficulty setting limits for himself and others, has a chronic alcohol abuse problem and requires a very structured environment in order to be successful at the most basic activities of daily living". Mr. Scott then goes on to relate Peter's difficulties with the criminal justice system: a fraud conviction, an assault charge and breach of probation charges as a result of missing meetings with his probation officer. Mr. Scott in the second last paragraph pleads for Peter's inclusion saying, "I am sure you know that people in Peter's situation are numerous and unfortunately, resources for people like him are virtually non existent." Incidentally Peter was not admitted into that program. Melanie Caribou, the community

service worker for the Norman region in The Pas and the person responsible for Peter Stevenson sent letters to various places trying to find help. She speaks of Peter as being unable to resist binge drinking and spending time with people who negatively influenced his behaviour. The file also indicates that Peter had difficulty remembering dates and times. There are reports indicating that he functioned at about a grade 6 level and had an I.Q. of only 77. There was also information about how Peter did not like to be controlled even as a young adolescent. It also is evident that Peter could not appreciate the consequences of his actions, one of the most serious consequences of suffering from F.A.S. In particular he could not follow rules and as a result got into serious trouble, especially with his landlords, to the point where Peter could not obtain housing. It was clear that Peter needed structure, supervision and support and someone that would assist him in making the right choices. That's not to say that this was an easy thing to accomplish as the files also indicate that Peter was also resistant.

It's obvious that earlier on and near the outset of Peter Stevenson's psychiatric difficulties there was a great deal of sharing both between Community Living, especially Melody Caribou and Dr. Jim Willows of the Selkirk Mental Health Centre, one of the psychiatrists who previously had treated Peter Stevenson. They were sharing back and forth and in particular Melody Caribou did receive a copy of Dr. Willow's discharge summary for the period of Peter's stay between May 5, 1999 and December 16, 1999. Dr. Willows, in the form where it indicated course in hospital, indicates that Peter was an involuntary patient. "He was initially placed on the open ward; however due to the difficulty in controlling his behaviour he was quickly transferred to the locked ward. It was felt that the most likely

diagnosis was substance induced, psychotic disorder and cognitive impairment secondary to fetal alcohol syndrome. It was felt milieu therapy of the hospital and no alcohol or marijuana while in hospital would have a positive influence over his condition.

On one occasion when he was first admitted, he was placed in a seclusion room due to his agitated behaviour. He was screaming and banging his body into the wall. He was unable to be settled with verbal discussion and on several occasions required dosages of Clopixol of up to 100 mg. IM." Peter's behaviour improved and eventually by the time of his discharge he was much more settled and his medications had been greatly reduced. Dr. Willows commented as well on Peter's lack of housing in the following fashion, "The length of Peter's admission was not due to his symptomology but was a result of our inability to find appropriate housing for him". Peter spent the last several months in hospital waiting placement. Also dealing with the issue of housing Melanie Caribou writes to Valhalla on October 28, 1999. She states,

> "Dr. Willows has recommended a living situation for Peter that has rules that bend. Dr. Willows feels that Peter will do nicely in an environment that has structure where people understand his needs to be flexible to the structure. Dr. Willows also stressed Peter's need to abstain from mood altering substances. There is currently no facility even remotely resembling the type that Dr. Willows is recommending for Peter in The Pas. Even if there was an endless supply of money for independent living support hours, Peter had used up all his chips with the landlords in this community. Even with myself as a reference they have had too many bad experiences to give him another chance."

One of the other problems Peter had was with his substance abuse which had become an extremely complicating factor in his life. Attempts to have him placed in a substance abuse treatment facility proved difficult. Melody Caribou wrote his probation officer on January

29, 1999 with the following comments: "We have been attempting to refer Peter to other treatment units, but we have not been able to locate one equipped for Peter's special needs. Peter's special intellectual needs dictate that he would require a modified program from that of the main street treatment curriculum. This would be the only way to ensure Peter's full comprehension and appreciation of the treatment facility experience." She asked the probation officer not to have Mr. Stevenson further charged as a result of his being unable to comply with the conditions of attending treatment.

It did not appear that there was the same degree of sharing of information which took place in the time period closer to Mr. Stevenson's death. It should be noted that the psychiatric nurses who treated Peter and the psychiatric aid who treated Peter testified at the inquest that they did not have very extensive knowledge about Fetal Alcohol Spectrum Disorder. Dr. Medd was of the opinion that this wasn't an important factor to take into account in Peter's treatment especially when he was in the acute phases of his schizophrenia. I note however that there had been at least four prior admissions to The Pas psychiatric ward. There was also some concern about the extent of Mr. Stevenson's psychiatric illness and that the severity of it was not fully known or comprehended by those who worked at The Supported Living Program and Services for People with Disabilities Division. There were in my opinion several areas where better communications between Community Mental Health and the psychiatric ward at The Pas Hospital with The Assisted Living Program could have been beneficial in the long term for Peter, especially when it came to the monitoring of the taking of his medications and reminding him to do so. This may have prevented him from relapsing into the psychotic episode which returned him to the hospital in June, 2004.

A 66-page review of Mr. Stevenson's file with The Department of Family Services and Housing Supported Living Program Services for Persons with Disabilities Division was undertaken by Loretta Ann Doyle who testified at the inquest. A copy of this report was apparently sent to the Deputy Minister and to the Norman Regional Director. She concludes with the following recommendations:

"Recommendations

Service Delivery

1. that the region institute cross-program annual reviews for those participants where multiple programs or services seem to be involved;
2. that the region initiate a partnership (e.g. services protocol) with Mental Health services to monitor and serve clients in common.
3. That the Region ensure that the file notation be completed in more detail and a timely manner.

Program/Policy

1. That the Department of Family Services through Services for Persons with Disabilities explore with other relevant departments the development of and/or coordination of services to adults with F.A.S. including

   a.) housing options and models;

   b.) residential support services;

c.) treatment services for dual diagnosed participants (e.g. person with intellectual disability and mental disorder)."

I concur with her recommendations. One cannot help but wonder that if proper housing options existed for Peter if he would, in fact, in the end have been required to have been in hospital and if he would have suffered from the symptoms of schizophrenia to the extent that he did, especially, if there had been proper monitoring of his medications from the onset of his illness. The witness further testified that in Winnipeg there is a particular program called Life Journeys with intensive one to one mentoring for individuals suffering with F.A.S. who are living in the community. Something like that might be a good start in the Norman region where the number of people suffering from F.A.S.D. is significantly elevated. When asked, Dr. Medd thought that special housing was also required for people with major mental illnesses. When asked to express his best scenario situation, he thought of a group home setting with involvement from the community mental health, a multi-disciplinary staff with 24 hour supervision, properly trained individuals perhaps being able to dispense the medication with proper sharing of information between the various disciplines. He indicated he would be happily involved if such a place could be provided. He also was of the opinion that this could impact on the relapse rates and therefore perhaps diminish the required hospital stays. He thought that it could perhaps help reduce the symptomology of the disease as well as improve the socialization skills of the resident. For someone like Peter it would certainly reduce the poverty of his existence. Dr. Medd further commented that such a proper type of housing is especially important in an area such as The Pas where some of his patients come from other areas in the Norman region especially from some of the northern remote communities. Such a facility would need to be tolerant as the treatment plan changes.

It would be much easier for patients especially from reserves as they easily get lost. Dr. Medd had made a point of commenting that homelessness was a major problem for people suffering from schizophrenia. He stated that the funding just has not kept up for the institutionalization for those individuals.

Jan Modler, the program manager for Supported Living Program Norman Region also testified at the inquest and provided us with information as to what services were available. I am satisfied that insofar as the services that are now available that Peter received as much assistance as could reasonably be provided to him. Notwithstanding that he did not necessarily fit the I.Q. criteria, special arrangements were made to continue to assist him. In part, this helped him significantly, especially insofar as the supported employment program was concerned. Ms. Modler also testified as to a new protocol through Justice that is in place for some individuals where there is a sharing of information. Apparently Justice, Family Services and Health are all involved and it is a protocol to share information for high-risk people. Apparently this is finally happening and comes as a result of recommendations made by Judge Collerman as a result of the Sarah Kelly Inquest. Ms. Modler was not able to tell us if Mr. Stevenson would have fallen into this program. It's a question of risk, mental health and cognitive limitations and balancing factors. Perhaps that type of protocol could be extended so that it could encompass people like Mr. Stevenson. Ms. Modler also agreed that there would be a need for the type of residence that was contemplated by Dr. Medd. She did indicate, however, that the Supported Living portion of the program is a discretionary program and that they have to live within their budget. That generally speaking they are not able to provide supports for people who are suffering from Fetal Alcohol Spectrum Disorder

if their I.Q. was over 70 but that exceptions could be made if there was someone suffering from a psychiatric disability as well. The other factor which must be taken into account is that the program is only available for people who are mentally incapacitated before they reach the age of 18 years. She commented that there are no services available for individuals who do not fit within the parameters of the program.

She did confirm that mental health does have a proctor service which is quite similar to their direct services workers program. It would appear that in a case such as Mr. Stevenson's, that there would be some room for incorporation of the work done by the proctor and the direct services worker. When questioned by Mr. Head, Ms. Modler did indicate though that insofar as Peter Stevenson was concerned she was not aware of any lack of funding for the services she was able to provide to Peter in the 6 months prior to his death. The only restriction for Peter Stevenson would be that the supported living program doesn't provide services for people who actually live on a reserve. I find it somewhat ironic that because Peter didn't have a home anywhere that he couldn't be said to be living on a reserve and therefore was entitled to some services.

During Peter's relatively short life it could never be said that he had a stable housing situation. Once he became an adult he spent time at various apartments for short durations until he was kicked out because of misbehaviour or misconduct. He spent a short period of time at The Pas jail for convictions for violence. He spent time at the Brandon Mental Health Centre, the Selkirk Mental Health Centre, and at The Pas psychiatric ward on at least four occasions. Other than that he bounced around from relative to relative or friend to friend

before ending up sleeping with dogs smelling of urine. Surely our society can provide some type of appropriate stable housing for the Peter Stevensons of our society, those who suffer from the dual burden of Fetal Alcohol Spectrum Disorder and mental illnesses such as chronic paranoid schizophrenia. We must remember that it was a combination of factors that brought Peter to The Pas psychiatric ward where he died in the manner he did. By addressing some of these factors we can perhaps prevent similar deaths in the future from occurring.

Recommendations

1.) I recommend that there be an awareness campaign and training for all of those who work in psychiatric wards, hospitals, emergency rooms, security and law enforcement and for all those who may transport mentally ill patients, as to the signs, symptoms and potential outcome of excited delirium.

2.) Specifically awareness and training for the above persons of the possible risks to the life of an individual who is restrained in the prone position for any length of time especially for an individual who may be at higher risk of dying from excited delirium, i.e. psychiatric patients, especially if on anti psychotic drugs and known users of cocaine or crystal meth.

3.) The establishment of a protocol in order that information that is known by one care giving governmental agency care be shared with other such departments or agencies where it is reasonable to believe that the sharing of the information could be in the best interests of the client/patient. In

particular in this type of situation that the psychiatric ward, community mental health and the supported living program not only share their information but use their resources in an integrated fashion in order to better serve the needs of the client/patient. I note that Mr. Stevenson also had some involvement in the justice system as well and as such this sharing and integration could extend as well to services such as probation and/or corrections. The hope is that by better serving the individual, the less stressors he may be faced with and therefore it may be less likely that his schizophrenia would reach an acute phase and that he would require hospitalization and find himself in the situation that Mr. Stevenson was in.

4.) That to the fullest extent possible when dealing with individuals such as Mr. Stevenson that all possible efforts be made and care taken to avoid that person from entering into this excited delirium state recognizing that once it occurs it can lead to fatal consequences.

5.) That recognizing that experience is one of the best tools in learning how to communicate and deal with psychotic or delirious individuals and that junior staff learn from more experienced staff (while acknowledging the difficulties that exist in obtaining medical staff in Northern Manitoba) that as much as possible that less experienced staff in the psychiatric ward be partnered with someone having more extensive experience.

6.) Recognizing the role that education of the psychiatric patient by the nurses plays in his long term recovery and management of the patient's disease, that there is a high prevalence of F.A.S.D. in the Norman region and that

there are patients who suffer from both F.A.S.D. and psychiatric illnesses, I recommend that a better understanding of the consequential features of F.A.S.D. should be provided to nurses, aids and physicians through their curriculum and by the attendance of compulsory training seminars thereafter.

7.) The E.M.S. personnel are in charge of security at The Pas Health Complex and they may or may not always be there, especially if on a call. In this case because of the tremendous physical exertion that the personnel exerted in restraining Mr. Stevenson one cannot but wonder to what extent they could properly immediately thereafter carry out their usual life saving functions as paramedics both with that patient or if required for another call. The paramedics also seemed to view their two rolls as somewhat in conflict. It may be wise for the Health Authority to reconsider the current situation and to consider the use of full time, properly trained security personnel. In any event I recommend that immediate training be provided to those who will be responsible for providing security at the hospital in the proper tactics to be used in restraining a violent individual. We heard from Staff Sergeant Mancini that such training is provided on a regular basis to the R.C.M.P. and that it may also be available through the law enforcement program at University College of the North. We heard that there is a close working relationship between the R.C.M.P. and the hospital and perhaps the restraint training could be carried out together.

8.) We heard evidence that Mr. Stevenson's violent behaviour involved the use of his hands, (i.e. throwing or swinging chairs, holding the upper body or wanting to punch Dan Pommer). If the use of some form of handcuff was available to the E.M.S. staff (or those who will be responsible for security) it may be that they could have secured Mr. Stevenson's hands and allowed him up from the prone position much more quickly and taken him into the seclusion room until the arrival of police. I recommend that such handcuffs be provided for the security personnel and that they be trained in the proper use of same.

9.) There are too many in out society such as Mr. Stevenson who because of a disability be it schizophrenia, F.A.S.D. or a combination of both who are unable to obtain appropriate or any housing and this may exacerbate their condition leading to prolonged hospital stays at considerable expense or stays at the local jail or even provincial correctional facility. I recommend as suggested by Dr. Medd, Janet Modler, Lorette Doyle and Donna Jansen that a properly staffed and well funded supportive housing unit be operated by the department of family services and housing with involvement from community mental health for individuals in Peter Stevenson's situation.

10.) The evidence indicated that Peter Stevenson was probably an alcoholic. We know that his consumption of alcohol was one of the factors that may have precipitated the confrontation which let to the delirium which eventually caused his death. Alcohol may even have had some actual

physiological role in the whole series of factors which lead to his death. Peter Stevenson had been through the local alcohol residential treatment program in The Pas three times and it was determined that he was not a suitable candidate for one of the other programs. He was not able to benefit fully from these programs in part because of the cognitive deficits he suffered as a result of his F.A.S. There are a large number of people in the Norman Region who suffers from F.A.S.D. and have significant substance abuse problems. I would recommend that a modified program be created for these individuals that takes into account the special learning difficulties often encountered by persons with F.A.S.D. and that it be provided within a residential substance abuse treatment facility.

11.) We heard evidence that the hospital made certain changes subsequent to Peter Stevenson's death. In particular there is now oxygen available on the psychiatric ward, a proper stretcher is available on the 4th floor very near the entrance to the psychiatric ward, and that there is regular, daily testing of the suction device. Whether or not having these medical devices available would have done anything to change the outcome in Peter's case once he arrested cannot be answered. (The important thing is to recognize and attempt to medically deal with excited delirium before it reaches that stage). I commend the hospital for making those improvements and recommend that they remain in place.

12.) There is so much that is unknown about what role clozapine may have played in Peter Stevenson's death. I recommend that further, scientific

study be encouraged in order to determine if possible how clozapine contributed if at all to sudden cardiac death. Mr. Thurmeier, the psychiatric pharmacist expert stated that be would be doing more and closer heart monitoring for his patients on clozapine. I believe that this would constitute good practice and I recommend that weekly E.K.G. heart monitoring be carried out for all patients who are on clozapine during the titration phase and for a reasonable period thereafter to determine if clozapine is having a noticeable change to the patient's heart.

13.) Peter was being helped by Walter Mink the direct service worker. Mr. Mink acknowledged that he didn't have a sufficient awareness of Mr. Stevenson's condition and felt overwhelmed by the situation. I recommend that direct service workers receive adequate training in order to be able to appreciate the actual needs of their clients and to be able to assist them accordingly

It is my hope that this report may serve as a resource for the better understanding of excited delirium. I wish to thank counsel who participated at the inquest for their valuable input. I also wish to express my gratitude to the family of the deceased for making it clear that they wanted the public to realize the devastating effects that F.A.S. can cause and the unfortunate unavailability of resources in the area.