RELEASE DATE: October 25, 2024

IN THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: *The Fatality Inquiries Act* C.C.S.M. c. F52

AND IN THE MATTER OF: An Inquest into the Death of Viengxay Chommany

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Report on Inquest and Recommendations of
Judge Lindy Choy
Issued: October 22, 2024

APPEARANCES:

Daniel Gunn and Patrick Gutowski, Inquest Counsel

Kimberly Carswell, Counsel for the Winnipeg Police Service

Kris Saxberg and Jodi Plenert, Counsel for the family of Viengxay Chommany

Robert Olson and Neil Steen, Counsel for Shared Health

M A N I T O B A

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL COURT JUDGE ON INQUEST

RESPECTING THE DEATH OF: Viengxay Chommany

An inquest respecting the death of Viengxay Chommany (DOB: 1 December 1976) was held on April 22, 23, 24, 25, 26, 29 and June 13, 2024, at the City of Winnipeg in the Province of Manitoba.

This report contains my findings, observations and recommendations. Attached as Exhibit A is a list of witnesses that were called to testify at the inquest, and as Exhibit B is a list of the exhibits that were filed during the inquest. Pursuant to the provisions of *The Fatality Inquiries Act*, I am ordering that all exhibits be returned to the Exhibit Officer, Provincial Court of Manitoba, to be released only upon application, with notice to any party with a privacy interest.

Dated at the City of Winnipeg, Manitoba, this 22nd day of October, 2024.

Original signed by Judge Choy
Judge Lindy Choy
Provincial Court of Manitoba

Copies to:

1. Chief Judge Ryan Rolston, Provincial Court of Manitoba
2. Dr. John Younes, Chief Medical Examiner
3. Hon. Matt Wiebe, Minister Responsible for *The Fatality Inquiries Act*
4. Jeremy Akerstream, Deputy Minister of Justice & Deputy Attorney General
5. Michael Conner, Assistant Deputy Attorney General
6. Michele Jules, Executive Director of Manitoba Prosecution Service
7. SMP Executive Assistants, Crown's Office
8. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court of Manitoba
9. Daniel Gunn and Patrick Gutowski, Inquest Counsel
10. Kimberly Carswell, Counsel for the Winnipeg Police Service
11. Robert Olson and Neil Steen, Counsel for Manitoba Shared Health
12. Kris Saxberg and Jodi Plenert, Counsel for the Family
13. Exhibit Coordinator, Provincial Court of Manitoba

Manitoba

THE FATALITY INQUIRIES ACT
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RESPECTING THE DEATH OF: Viengxay Chommany

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I. INTRODUCTION

[1] On August 4, 2019, Viengxay "Hip" Chommany passed away. He was only 42 years old. Mr. Chommany was someone who lived with mental illness for over two decades, managing it with medication and family support. For many years he functioned well, maintaining employment and engaging in the community. At times, however, he did not like taking the medication and when he stopped taking it, his symptoms would become more noticeable.

[2] On Friday, August 2, 2019, Mr. Chommany was having a bad night. He was hyperactive and agitated, could not settle, and was sweating profusely. He was showing characteristics of what at the time was referred to as "excited delirium".

[3] The Winnipeg Police Service ("WPS") was called to his home for assistance in managing his behaviour. Unfortunately, the situation escalated. Mr. Chommany ran from the home, and police gave chase. Police used verbal direction, soft open hand force, and tasers to apprehend him. He was taken to the ground and handcuffs and shackles were applied. While being restrained, Mr. Chommany stopped breathing. CPR was administered, but he suffered anoxic injury to his brain. He died in hospital two days later.

II. MANDATE OF INQUEST

[4] By letter dated January 14, 2021, an inquest into the death of Viengxay Chommany was ordered. The reason for the inquest was set out as follows:

1. To fulfill the requirement for an inquest, as defined in Section 19(5)(b) of *The Fatality Inquiries Act* (the "*Act*"):

Presumption of inquest

19(5) Subject to subsections (6) and (7), an inquest into a death must be held if

(a) The chief medical examiner has reasonable grounds to believe that the deceased person died as the result of the use of force by a peace officer who was acting in the course of duty; or

(b) At the time of death, the deceased person was

(i) in the custody of a peace officer,
(ii) a resident in a custodial facility,
(iii) an involuntary resident in a facility under *The Mental Health Act*, or
(iv) a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*.

2. To determine the circumstances relating to the death; and
3. To determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[5] In the one-year period preceding Mr. Chommany's death, five other men died while being restrained by Winnipeg police. Those cases differed from Mr. Chommany's in that the other men had either methamphetamine or cocaine in their systems when they died. A joint inquest into the deaths of Michael Fosseneuve, Patrick Gagnon, Michael Bagot, Sean Thompson and Randy Cochrane was held, and although this inquest was conducted separately, there is significant overlap between the matters examined and I have issued my reports for the two inquests concurrently.

III. PARTIES

[6] Initially, Mark Lafreniere was appointed Inquest Counsel. Subsequently, Daniel Gunn and Patrick Gutowski assumed conduct of the inquest.

[7] Prior to the hearing, standing was granted pursuant to section 28(1) of the *Act* to:

- Winnipeg Police Service, represented by Kimberly Carswell;
- The family of Viengxay Chommany, represented by Kris Saxberg and Jodi Plenert;
- Shared Health, represented by Robert Olson and Neil Steen.

[8] The inquest took place over seven days of hearing and was completed on June 13, 2024.

[9] This report will first review the circumstances surrounding Mr. Chommany's death. It will then examine the use of the term "excited delirium" and the ways in which we currently respond to a person exhibiting this constellation of behaviours. Finally, the report will consider recommendations for changes in programs, polices or practices which would serve to prevent similar deaths from occurring in the future.

IV. CIRCUMSTANCES OF DEATH

History of Mental Illness

[10] Viengxay Chommany was a 42-year-old man who lived in Winnipeg. His family and friends called him "Hip". He was married to Ratsamy (Sam) Chommany and had a large family who loved and supported him. He loved music, and even played in a band. Life, however, was not without challenges for Mr. Chommany. At age 21, he was diagnosed with bipolar disorder and schizophrenia and required prescription medication to control his symptoms. For many years, his condition was managed and he was able to function well. At times, however, he would tire of being

medicated, and he would stop taking his pills. When this happened, Mr. Chommany could become dysregulated, and sometimes his family required assistance in managing his behaviour.

Police encounter on July 26, 2019

[11] One of those times was on July 26, 2019. Mr. Chommany was off his medications and was talking incoherently. He could not sleep, and he would repeatedly go back and forth between his home and his mother's residence. Ms. Chommany felt he needed to go to the hospital and called the police for assistance. Csts. Chiborak and Grenkow attended and spent some time talking with Ms. Chommany, and then Mr. Chommany. The officers advised Ms. Chommany that they could not force him to go to the hospital and that only a doctor had the authority to admit him. By that time, Mr. Chommany's behaviour had settled and police assessed that he was not a threat to himself or others. Police recommended that a doctor appointment be scheduled and Ms. Chommany was left with information about arranging an involuntary admission should he not go.

[12] The matter ended there and there was no further issue.

Events of August 2, 2019

[13] A few days later, on Friday, August 2, 2019, at about 00:30 in the morning, Mr. Chommany was again exhibiting erratic behaviour. Ms. Chommany called 911 and asked for police to come pick her husband up indicating that he had a mental

illness and refused to take his pills. She was transferred to police emergency and in response to questions, she advised that he was yelling and harassing her. She was not hurt but he was grabbing her. He did not have any weapons. She said he had not ever been violent with her before, this was the first time.

[14] WPS then dispatched a unit to respond to a call for a domestic situation. At 00:51 Csts. Clark and Kiziak arrived at the home. They came up to the front door and rang the doorbell. Inside, Ms. Chommany went to answer the door but Mr. Chommany physically stopped her. Looking through the glass, Cst. Kiziak saw this occur and felt she had a look of terror on her face. He immediately kicked the door open and got between the Chommanys to prevent any further assault.

[15] There is some discrepancy in the evidence as to what occurred after police entered the residence. Ms. Chommany recalls that police said to Mr. Chommany "don't put your hands on her" and they were separated. Mr. Chommany was escorted to the kitchen area and was told to sit down. Mr. Chommany complied, but then asked police whether that was a real gun and ran frightened and shoeless out the front door.

[16] Csts. Kiziak and Clark recall events slightly differently. Cst. Kiziak testified that they directed Mr. Chommany to the kitchen, but he refused to sit. The officers grabbed his arms and told him he was under arrest. Mr. Chommany said no and started to struggle with them. As Mr. Chommany was perspiring profusely, he

slipped free from their grasp and ran from the house. Cst. Clark relates a similar version of events, except he noted that Mr. Chommany refused to sit and came towards the officers in a fighting stance.

[17] For the purposes of this inquest report, it is not necessary to make a determination of all of the facts. I do accept that police would have advised Mr. Chommany that he was under arrest. What is apparent from both versions is that Mr. Chommany remained in a highly agitated state and ran out the door before the officers could interact with him much further.

[18] After Mr. Chommany ran out the front door, the two officers gave chase. They commanded him to stop and get on the ground. As he ran, Mr. Chommany yelled back that he would kill them and that they were dead. At about 00:54, Mr. Chommany stopped in the street and assumed a fighting stance. Cst. Clark pulled out his conductive energy device ("CEW"), otherwise known as a taser, and arced it. Sometimes this show of force will cause people to become compliant, however Mr. Chommany just turned around and started running again.

[19] Cst. Kiziak was the next to catch up to Mr. Chommany. As Cst. Kiziak approached, Mr. Chommany threatened to kill him and raised his hands in a fighting stance. Civilian witnesses confirm that they heard the yelling and Mr. Chommany's threats to kill. Cst. Kiziak testified that he believed Mr. Chommany to be in an agitated chaotic state and that they would need to quickly get him into custody or

else be at risk of medical problems. He therefore deployed his taser at about 00:55. Mr. Chommany fell to the ground, but as he did so, one of the prongs dislodged so he was able to get up and run again.

[20] The officers continued the pursuit and caught up again with Mr. Chommany in the front yard of a home. Cst. Clark testified that he grabbed Mr. Chommany and put him on the ground on his back. Mr. Chommany continued to fight so Cst. Clark got on top of him trying to get him into handcuffs. Mr. Chommany is described by both officers as continuing to struggle and he ignored their commands to stop resisting.

[21] Cst. Kiziak testified to punching Mr. Chommany once in the right shoulder to get him to let go of his partner's neck and once in the right thigh. Cst. Clark described Mr. Chommany as continually grabbing and punching at him. As their efforts were not working, Cst. Clark deployed his CEW at 00:58 and while it did not achieve full neuromuscular incapacitation, it did allow them to get Mr. Chommany's hands behind his back and in handcuffs.

[22] Despite the handcuffs, Mr. Chommany continued to kick and thrash while on the ground. At about 00:57, Air One had arrived on scene, and shortly thereafter at 00:59 P/Sgt. Robert also arrived. Cst. Kiziak called for an ambulance to attend to remove the taser darts. At 01:02, P/Sgt. Robert voiced that they had to apply leg shackles to Mr. Chommany and requested another unit. Mr. Chommany continued

to actively resist and at one point, wrapped the shackles around Cst. Kiziak's leg, pulling his shoe off and causing him to fall on the sidewalk.

[23] Because he continued to struggle, the officers used their hands to hold Mr. Chommany down. Cst. Kiziak described holding his legs, while Cst. Clark was positioned at his upper torso.

[24] At some point, Mr. Chommany just stopped struggling. The officers got off him and observed that his breathing was shallow and laboured. At 01:04, P/Sgt. Robert requested the ambulance to come on a rush basis.

[25] Another police unit with Csts. Jones and Jardine arrived just as the officers noticed the change in breathing and P/Sgt. Robert was voicing for the ambulance on a rush basis. At 01:07, Winnipeg Fire and Paramedic Service ("WFPS") unit Rescue 8 arrived and primary care paramedics ("PCP") Woloshyn and Mutual began administering CPR. At 01:14, an ambulance with advanced care paramedic ("ACP") Stubbe and PCP Haynes arrived and assumed medical care. Mr. Chommany was transferred to the ambulance and taken to St. Boniface hospital in critical condition.

[26] The evidence varies with respect to the positioning of Mr. Chommany on the ground. The police officers testified that Mr. Chommany was moved into the recovery position at 01:04 when his breathing changed. Prior to that, Cst. Clark, P/Sgt. Robert and Cst. Jones testified that Mr. Chommany had been prone, or face down on the ground. Cst. Kiziak recalled Mr. Chommany to be on his back.

[27] The crew from Rescue 8 recall differently. Three of the members, Lt. Stasiuk, PCP Mutual and firefighter Verhaeghe recall arriving to see Mr. Chommany prone and WPS officers standing around him. The fourth member PCP Woloshyn believed Mr. Chommany to be lying on his back with an officer holding his feet. When PCP Mutual assessed Mr. Chommany, no pulse was found.

[28] For the purposes of this inquest report, my attention is focussed on the prone positioning of a restrained individual. All witnesses acknowledge that at some point, Mr. Chommany was held on the ground in handcuffs in a front down position. The officers' testimony would have Mr. Chommany in that position from about 00:58 when the taser was deployed until 01:04 when he stopped struggling and his breathing changed. Rescue 8 arrived at 01:07, so Mr. Chommany may have been in that position for a further three minutes, at a time when his breathing had already been observed to be laboured.

[29] As noted earlier, when assessed by the crew from Rescue 8 at 01:07, Mr. Chommany did not have a pulse. P/Sgt. Robert testified that after they moved Mr. Chommany into the recovery position, he continued to monitor his condition and that he watched his breathing the whole time. He testified that Mr. Chommany continued to have shallow breathing and that CPR was not necessary because if he is breathing, his heart is still going. Cst. Kiziak's evidence was that there was shallow laboured breathing which did not stop until shortly after Csts. Jones and Jardine

arrived. Cst. Clark noted laboured breathing but once the other unit arrived, he stepped back to catch his breath. He testified that he checked for chest movement in order to ensure breathing. Cst. Jones testified that they were all monitoring Mr. Chommany and that she knew he was breathing because he was making moaning sounds.

[30] When Mr. Chommany was taken to hospital, it should have been known to all officers that his medical situation was extremely serious. At 01:14, police radio communications indicated, "Male now unresponsive – performing CPR." At 01:27 it indicated, "Susp has a pulse." The entry at 01:28 indicated, "Call back: Chommany, Sam … to supvs and duty – male going to STB critical."

[31] The evidence of Ms. Chommany was that after her husband ran from the residence, she remained there. She started to sweep the entryway, but was told by WPS officers who came to the house not to clean up because it may be evidence. She testified that after waiting a while, the officers took her to the station for questioning. She knew nothing about what had happened to her husband, and in fact she brought along a pair of slippers for him because he had run out of the house with no shoes. She believed that he was somewhere at the police station. When waiting there, she asked if she could give him the slippers and they told her to just keep them for now and she could give them to him later.

[32] At the station, she waited for several hours before police took a recorded statement from her at 03:03. It was only after the questioning was completed that police told Ms. Chommany that they would now take her to where her husband was at the hospital. Prior to this, no one had informed her of the fact that her husband was in hospital in critical condition.

[33] Mr. Chommany remained in hospital until August 4, 2019, when he was taken off life support and passed away.

V. DISCUSSION OF "EXCITED DELIRIUM"

Autopsy Report

[34] The report of medical examiner was signed on June 2, 2020, by Dr. John Younes, Chief Medical Examiner for the Province of Manitoba. Dr. Younes testified at the inquest and explained that while he was the medical examiner charged with investigation of Mr. Chommany's death, Dr. David Taylor performed the autopsy. Dr. Taylor is no longer practicing in Manitoba.

[35] In both the autopsy report form and the report of medical examiner, the Part I immediate cause of death is described as:

a. complications of anoxic brain injury, due to or as consequence of
b. probable arrhythmia, due to or as a consequence of
c. excited delirium.

[36] Part II sets out other significant conditions contributing to the death but not causally related to the immediate cause. This was completed to indicate "physiologic stress of physical struggle and restraint".

[37] Dr. Younes explained that while the term "excited delirium" was first coined in the 1980s to describe a pattern of behaviour in people abusing stimulant drugs or who had mental health disorders, there has been a movement away from use of the term. Over the decades it was recognized that the constellation of symptoms typically identified as excited delirium would not be cause for a fatality in and of itself. Use of the term would have a tendency to disengage from a more detailed examination of death by simply attributing the death to the constellation of symptoms. The preferred verbiage now is to specifically attribute the cause of death to a specific cardiac arrhythmia. Accordingly, Dr. Younes suggested that if preparing a report with respect to Mr. Chommany's death today, his cause of death would likely be listed in Part I as:

a. complications from anoxic brain injury; due to or as consequence of
b. cardiac arrest; due to or as a consequence of
c. psychosis induced cardiac arrhythmia.

[38] Part II: physiologic stress of physical struggle and restraint.

Theory of Death

[39] Dr. Younes indicated that when there is a death following prolonged struggle with police, the dissident often has an underlying heart issue or drug use. In this case, Mr. Chommany had no significant underlying physical disease. His heart was normal, he had no underlying disease of the lungs or the kidneys, and toxicology tests showed no illicit drugs in his system and only the presence of olanzapine. Due to the small amount of blood available for testing, they were unfortunately not able to determine the levels of olanzapine in Mr. Chommany's system.

[40] There were a number of blunt force injuries which Dr. Younes described as trivial and were not significant in the causation of death.

[41] He also testified that based on information that Mr. Chommany continued to resist officers after the taser was administered, he ruled out the use of taser as being the cause of Mr. Chommany's death. Had the use of the taser been the cause of Mr. Chommany's death, the effect would have been almost immediate, with loss of consciousness within seconds and he would not have continued fighting.

[42] Dr. Younes explained that even an individual with a healthy heart can die as a result of elevated adrenaline levels. In this case, Mr. Chommany had a history of mental illness. He experienced a psychotic episode that can be caused by mental illness such a schizoaffective disorder or schizophrenia. This led to his involvement in an altercation in which he fled from police, was tasered and continued to struggle.

The underlying high adrenaline state caused by the psychotic episode and the prolonged violent interaction with police resulted in his exposure to too much adrenaline for too long. His heart's demand for oxygen would have outstripped its supply affecting its electrical system and causing cardiac arrhythmia. This caused cardiac arrest which halted the supply of blood to his brain and caused his death.

[43] With respect to the presence of olanzapine, Dr. Younes acknowledged that this could have been another factor which predisposed Mr. Chommany to arrhythmia. Olanzapine is an anti psychotic medication which can cause increased risk of arrhythmia, especially with prolonged exertion. It is a medication taken by individuals with schizophrenia and Dr. Younes noted that persons with schizophrenia have higher levels of sudden unexpected death, which may be related to episodes of adrenaline release.

[44] Dr. Younes also discussed the possibility of acidosis as being a contributing factor. He explained that bodily functions require a minimal level of PH in the blood. If blood becomes too acidic from either metabolic acidosis caused by lactic acid or from respiratory acidosis caused by a build up of carbon dioxide in the system, this could be a contributor to deaths. While this approach has not yet been accepted by forensics as a cause of death in and of itself, a struggle can certainly contribute to acidosis and so is something that could be a contributor to these unexplained deaths.

[45] As observed in the companion inquest into the deaths of Fossenuve, Gagnon, Bagot, Thompson and Cochrane, regardless of the specific physiological process involved, the simple fact of engaging in a maximal effort struggle while in a psychotic episode greatly increases the risk of developing cardiac arrhythmia.

[46] In the context of this inquest, I view the term "excited delirium" as referring to the constellation of behavioural traits being exhibited by Mr. Chommany while he was in a psychotic state. For the purposes of this report, I will refer to the behaviour as hyperactive agitation.

VI. WPS AND WFPS PROTOCOLS FOR DEALING WITH HYPERACTIVE AGITATION

[47] In both this inquest and the companion inquest, I heard extensive evidence describing the manner in which WPS and WFPS respond to calls for assistance regarding individuals who are exhibiting hyperactive agitated behaviour. The circumstances in this inquest differ from the others because Mr. Chommany had not ingested any stimulants (either cocaine or amphetamine) which contributed to his erratic behaviour.

[48] Regardless of whether an individual's agitated behaviour is rooted in psychosis or substance use, the constellation of symptoms typically observed include the following:

- Pain tolerance;

- Constant/ near constant activity;
- Not responsive to police presence;
- Superhuman strength;
- Rapid breathing;
- Does not fatigue;
- Naked/inappropriately clothed;
- Sweating profusely;
- Tactile hyperthermia;
- Glass attraction/destruction.

[49] In many cases, the agitated behaviour escalates to the point where a call is made to 911 to request assistance. In this case, Ms. Chommany called asking for police assistance to take her husband to the hospital to be monitored.

WPS-WFPS Response

[50] In the companion inquest report, I summarize the evidence regarding the policies and procedures followed by WPS and WFPS in cases of hyperactive agitation, which WPS refers to as an agitated chaotic event, or "ACE".

[51] Overall, the WPS-WFPS response generally unfolds as follows. WPS is dispatched to respond to a call for assistance. When they arrive, the individual is exhibiting hyperactive, agitated behaviour. Once the WPS officer recognizes the ACE situation, it is considered a medical emergency, and an advanced care

paramedic is requested to manage the situation pharmacologically by administering chemical restraint.

[52] Sometimes, WFPS is the first to be dispatched. In those cases, once the paramedics recognize that the situation is escalating or there is a threat of harm, WPS assistance is requested.

[53] As WFPS policy is that paramedics are not to administer medical care until such time as the individual is under control, the responsibility rests with WPS to moderate the individual's behaviour to the point where the medical care/chemical restraint can be given.

VII. IDENTIFYING TARGET AREAS

[54] In reviewing the events surrounding Mr. Chommany's death, as well as the five deaths examined in the other inquest, I have identified two areas where improvements could be made:

- Target Area 1: How to moderate the agitated individual's behaviour to enable administration medical care; and
- Target Area 2: How to minimize the time between when police have brought the individual's behaviour under control, and when the sedative can be administered.

Target Area 1: How to Moderate the Person's Behaviour

[55] Police are charged with the very difficult task of subduing the hyperactive agitated individual into a state where chemical restraint can be safely administered. They are responsible for making the situation safe for the paramedics, the individual, and the police themselves. It must be recognized that they are carrying out this task in an uncontrolled, non-clinical setting which may be fraught with unknown dangers, including concealed weapons.

[56] There were two practices examined during the course of this inquest and the companion inquest:

1. De-escalation
2. Restraint techniques

De-escalation

[57] WPS officers are provided with training in de-escalation and mental health knowledge. They also undergo live scenario training which tests the member's ability to make decisions under stress. Since 2023, in-service training that members take began to include a refresher on ACE incidents, to ensure members are up to date on practices and techniques. The specifics of the WPS training are set out in greater detail in the companion inquest report.

[58] In this inquest, Dr. Skye Rousseau provided testimony as an expert in forensic psychiatry. Dr. Rousseau is a Psychiatrist with Adult Forensic Services, and

Assistant Professor with the University of Manitoba. He has been a psychiatrist since 2017 and has worked in MD Care, in Corrections at the Winnipeg Remand Centre, and as part of the Forensic Assertive Community Treatment Team in Winnipeg.

[59] Dr. Rousseau was asked to review the circumstances surrounding Mr. Chommany's death to consider whether a different approach from officers during their encounter may have improved the outcome.

Review of Literature

[60] Dr. Rousseau first conducted a limited review of the literature for use of force police encounters where mental illness is a factor. He observed that while most media attention focuses on ethnic minority status as a risk factor during interactions with police, available evidence suggests that suffering from or displaying signs of a mental illness is a far greater risk factor for likelihood of dying or suffering physical harm during altercations with police.

[61] Contributory factors which may be connected to this is the deinstitutionalization of the mentally ill, which has likely led to dramatically increased numbers of people in the community with untreated mental illness and increased violence as a consequence. Increased availability of street drugs that tend to cause or intensify both symptoms of mental illness (such as psychosis) and aggressive behaviour may be another factor.

[62] Unfortunately, there is a lack of reliable research and data on effective approaches to engaging with mentally ill persons that will help to improve interactions, and decrease both civilian fatalities and harm to police officers. The most widely utilized intervention is the use of Crisis Intervention Team ("CIT") training which provides specialized training for officers in de-escalation techniques. Dr. Rousseau noted that the Winnipeg Alternative Response to Citizens in Crisis program is a form of CIT team.

[63] Despite widespread use, the evidence for CIT teams actually improving measurable outcomes is limited. There appears to be a clear link between CIT training and reducing officers' stigma towards the mentally ill, however actual improvements in behaviour and outcomes are less proven, due to lack of data. Dr. Rousseau added that this does not necessarily mean they are ineffective, just that there is little research in this area.

[64] The lack of reliable research and data is not unique to the area of police intervention. Management of aggressive, psychotic behaviour is a daily challenge in psychiatric care settings internationally. In 2017, the Cochrane Library published a review and concluded that there is no trial based evidence currently available assessing the effectiveness of de-escalation techniques for managing aggression or agitation.

[65] Dr. Rousseau did cite a program which was developed by the University of Alberta which focussed on a more behavioural approach. Instead of attempting to change police officers' beliefs and opinions, officers were put through practice scenarios and role-playing exercises.

[66] Prior to the exercises, officers were provided training that placed an emphasis on active listening skills such as paraphrasing, emotional labelling, mirroring, minimal encouragers, summarizing and use of silence. Officers were made aware that their ability to develop rapport with the subject would be evaluated as well as the ability to de-escalate situations, the use of appropriate body language, and the ability to demonstrate empathy.

[67] After training, officers were put through role plays of various scenarios with trained actors. After role-playing a scenario, officers were provided feedback by both the actors and trained facilitators.

[68] The crux of this approach is the notion that it does not matter whether officers' beliefs and attitudes are changed with respect to stigma, but rather practicing and role-playing more empathetic behaviours may improve outcomes regardless of whether beliefs or opinions about mental illness change. Role-playing with constructive feedback may also create a sense of comfort and familiarity in officers that will help them feel more capable, and less quick to resort to use of force if it is not imminently necessary.

[69] The overall outcomes of the Edmonton project were positive. The main outcomes reported were a significant decrease in the amount of time spent per call for mental health calls and a dramatic decrease by 50 percent of the percentage of times any force was used in a mental health call.

Execution of De-escalation Techniques

[70] On reviewing the facts applicable to Mr. Chommany's situation, Dr. Rousseau questioned whether he was known by responding officers to have a mental illness. Whether this would have changed their approach is unclear, but Dr. Rousseau suggested that it may have been fitting to alter the approach if it is known that the subject may not be thinking rationally and may be paranoid, regardless of the underlying cause. Paranoia can dramatically alter a person's response to intimidation or anything that might make them feel cornered, and should always be a consideration when a person is known to have a history of psychosis.

[71] Dr. Rousseau observed that there appeared to be an urgency felt by officers to apprehend Mr. Chommany for reasons that were not readily apparent. In Dr. Rousseau's opinion, it may have been possible to give chase longer and attempt to avoid using a CEW, perhaps negotiating more with Mr. Chommany. Physical restraint can be necessary, but it does put a person at increased risk of cardiac overload asphyxiation and cardiac arrest, especially when they are in a psychotic state, whether drug induced or due to an endogenous mental illness.

[72] Dr. Rousseau suggested that scenario based role-playing training may have improved the outcome of the incident. Police may have possibly attempted to de-escalate with other less aggressive strategies before resorting to physically restraining Mr. Chommany or deploying a CEW. He opined that training in alternative techniques to be used in such situations where the subject of police pursuit is known to have a mental illness would likely reduce the probability of needing to use physical restraint in such situations in the future, and may also result in less agitation and less chance of a fatal outcome in cases where restraint is nonetheless used.

[73] My observations are that in Mr. Chommany's situation, there could well have been some opportunity for officers to attempt to de-escalate prior to resorting to physical restraint. I acknowledge that during the initial encounter at the house, there was no time to de-escalate as Mr. Chommany was being arrested and he almost immediately ran out of the house.

[74] The evidence of Cst. Clark is that when he first caught up to Mr. Chommany, he arced his CEW as a warning. I accept that by doing this, he was attempting de-escalation by utilizing an alternative to immediate use of physical force.

[75] Subsequently, however, when officers caught up to Mr. Chommany further up the street, there was some opportunity to de-escalate which does not appear to have been taken.

[76] A doorbell camera located across the street from where the apprehension occurred captured a brief unobstructed view of Mr. Chommany just moments before he was taken down by Cst. Clark. Mr. Chommany can be seen walking away from an officer, presumably Cst. Kiziak. Both are walking and the officer can be seen raising his arm and holding it outstretched towards Mr. Chommany. They are moving relatively slowly. Some movement can be seen in the shadows and then a loud yell can be heard, which was likely a noise made by Mr. Chommany as he was brought to the ground.

[77] It is not clear from the footage what was being said, but I agree with Dr. Rousseau that there may have been opportunity for de-escalation. Mr. Chommany was no longer running, suggesting that he was starting to tire, and it may have been possible at this point to call for an ambulance to administer chemical restraint and engage Mr. Chommany until their arrival. This possibility does not seem to have been contemplated by officers, despite recognizing that this was an ACE incident. It is notable that the paramedics had initially only been called for taser prong removal, and the advanced care paramedics were not requested until after Mr. Chommany went limp and stopped struggling.

Restraint Techniques

[78] If verbal de-escalation or other non-physical attempts to subdue the individual have had no effect and a reasonable amount of time has elapsed, police may be left with no other alternative but to physically restrain the individual.

[79] WPS police officers are trained to incapacitate the individual so restraints can be applied quickly with minimal physical force, and after restraints are applied, officers are instructed to control the individual with the least amount of intervention possible. Once restrained, the individual is moved into the recovery position so long as it is safe to do so.

[80] Sgt. Kelly Keith was qualified as an expert in police use of force and use of force training. Sgt. Keith has 34 years of police experience with multiple police departments and has in various capacities provided training to a wide range of peace officers both nationally and internationally.

Current WPS training

[81] Sgt. Keith discussed the WPS policy as follows:

> (WPS Officer Safety Unit) Cst. Russell advised that from 2011 to present WPS Officers are taught that when dealing with a violent subject they are to restrain the subject in the prone position. The officers apply what is called a shin pin restraint to the subject's buttocks area. A shin pin describes where an officer's foot is on the ground and the shin is pinning the subject down while handcuffs are applied. Cst. Russell advised that the goal is for the officers to only use this as a transitional position where the WPS members get the subject off the prone position when possible.
>
> Cst. Russell advised that starting in 2016 WPS members were taught that when a subject was exhibiting signs of what was at that time referred to as Excited Delirium, they were to wait for paramedics to attend the area if feasible. When paramedics arrived, they would stage nearby and wait for police to get physical control. It was recommended, if possible, to have a multiple member approach and to attempt

> avoiding applying pressure on the subject's back and were not to leave the subject in the prone position even by themselves. Once the subject was restrained, they were to have paramedics on scene to deal with any medical concerns.
>
> Since 2018 and continuing presently, WPS officers are trained that prone handcuffing is used for an active fighting subject and/or a subject that is high risk (ie. possible gun). A rip hobble (leg/ankle restraint) will be applied to prevent kicking and thrashing of the legs. Cst. Russell advised that the shin pin stays on while the rip hobble is applied at which time, the subject would be placed into the recovery position.

Execution of Restraint Techniques

[82] In the case of Mr. Chommany, the accounts vary as to when he was placed into the recovery position after handcuffs and shackles were applied. It is not disputed, however, that a CEW was deployed to gain control of him and that he was for a period of time shin pinned in the prone position.

[83] Sgt. Keith opined that putting Mr. Chommany in a prone position to gain control of him is consistent with the training of WPS and other police departments in Canada and the United States. It is acceptable because getting a combative subject down to the ground in a prone position allows officers to use the ground as a stable platform. They can then use less force on the subject due to the officer's position of advantage. The subject's ability to assault the police officers from this position is greatly mitigated and it allows officers a quick way to apply handcuffs.

[84] Sgt. Keith further advised that putting downward pressure on the hips or shoulder blade is best practice while putting a subject into handcuffs however once handcuffs are applied, most agencies in Canada including WPS recognize the need

to get the subject off their stomach. The WPS training states to not leave a subject in the prone position by themselves.

[85] As noted in the companion inquest report, knowing what we do about the physiological stress experienced by hyperactive agitated individuals and the increased risk of a cardiac event, it seems clear that minimizing the amount of time a handcuffed person is kept in the prone position must be emphasized in WPS training. This practice is already part of the instruction given to WPS members, but direction regarding the length of time the prone position may be maintained is imprecise. Members should be educated on the physiological risk factors which are present and be encouraged to restrain individuals in the prone position for the least amount of time possible.

[86] With respect to monitoring, an individual who is restrained with arms and legs tied is in an incredibly vulnerable position. Officers should be paying close and careful attention to the individual's physiological status at all times to ensure that assistance is available the moment it is required. Mere visual checks may not be sufficient.

Target Area 2: Minimize the Time Gap

[87] The second target area concerns how to expedite the delivery of chemical sedation to the individual.

[88] The current practice is that when police identify an event as one involving an ACE, they label it as a medical event and will call for an ambulance. In Mr. Chommany's case, an ambulance had been requested to pull out the taser darts, but a rush was not placed on the call until 01:04 when Mr. Chommany stopped resisting. Cst. Clark's evidence was that he did not identify this situation as an ACE event. Cst. Kiziak believed it was, and P/Sgt. Robert testified that at some point he believed it to be an ACE.

[89] In my view, there was opportunity to have called for advanced care paramedics on scene earlier. Earlier identification of the situation as being an ACE would have accelerated the call for an ambulance on rush. Reinforcement of training on recognizing the behavioural cues of an ACE would be beneficial.

[90] Further, having an advanced care paramedic immediately present on scene would greatly expedite medical care. In the companion inquest, I heard more detailed evidence regarding the concept of a specialized joint WPS-WFPS ACE response team for these types of events. There is already a similar concept instituted with respect to embedding a paramedic with the WPS Tactical Support team. Given the profound increase in calls for individuals experiencing ACE situations, creation of this specialized unit would certainly be warranted.

VIII. NEW INITIATIVES

Alternative Response to Citizens in Crisis

[91] Danielle Svenne, manager for Shared Health Crisis Response Services, and Inspector Helen Peters, WPS, provided the court with information regarding Alternative Response to Citizens in Crisis or "ARCC". ARCC is a pilot project which commenced at the end of 2021 as a joint undertaking between Shared Health and WPS. The mandate is to provide collaborative on-scene trauma informed responses to individuals in high-risk situations related to mental health and/or addiction issues in the City of Winnipeg. This pilot project pairs a police officer with a mental health clinician to bring mental health services into the community in response to certain calls for service.

[92] The project goals of ARCC are as follows:

- Provide an on-scene trauma informed response within the City of Winnipeg to mental health crisis calls for police service;
- Perform mental health assessment and intervention at home, when safe to do so;
- Improve access to mental health and substance use treatment for individuals experiencing crisis;
- Follow up a few days after the crisis episode;

- Stabilize and support individuals who frequently use crisis or emergency services.

[93] ARCC was designed to provide both a reactive (immediate response to dispatched police calls for service) and proactive (coordinated case managed follow up) response to those in need.

[94] With respect to reactive services, the ARCC team could be dispatched to events where general patrol has already deemed the situation to be safe. In that case, the ARCC team would act as the prime unit and the mental health clinician could do an assessment directly in the community resulting in one of three outcomes: the individual remains in the community, the individual remains in the community with follow-up, or the individual voluntarily goes to the Crisis Response Centre or "CRC".

[95] In situations where the general patrol is not able to de-escalate the situation to be a safe level, ARCC may still be available either in person or by consultation, as a resource for the general patrol which remains the primary unit. This would constitute the reactive portion of ARCC's services and during the pilot project from 2021 to early 2024, represented approximately 70 percent of ARCC time.

[96] The other 30 percent was dedicated to proactive work, which would include case management and dealing with individuals with high use of multiple services, as

well as providing follow-up support to families or individuals after the acute event is completed.

[97] In theory, ARCC would also monitor incoming 911 calls to see whether any ARCC intervention may be warranted on a particular call. In those cases, the ARCC team could self assign for non-urgent, non-criminal dispatchable calls for police. Unfortunately, due to resource limitations, the ARCC team is often maxed out and is unable to engage in this proactive work.

[98] The types of work the ARCC team typically performs includes:

- Consults pre-police attendance to provide additional information and support;
- Responding on scene with police;
- Consultation with police while on scene;
- Providing follow-up to police referrals.

[99] A significant advantage for the ARCC team is that the clinician is able to access CRC records and Shared Health electronic patient records to review for previous interactions the individual may have had with CRC or for mental health related hospital admissions. Access to e-charts also provides information with respect to medications. The goal would be to create some understanding as to the individual's situation so that before arriving on scene, officers may be informed of the types of issues the individual has encountered within the past 12 to 18 months. This gives the responding officers better perspective on what to expect.

[100] The ARCC pilot project has been considered a success and its availability has been expanded. Where it was initially available only during regular business hours, this has been increased to seven days per week. There is clear demand for the service, and it is hoped that the services will continue to receive greater funding so as the scope can be expanded.

[101] ARCC was not available in 2019 when Mr. Chommany was experiencing his crisis. Both Ms. Svenne and Inspector Peters reviewed the 911 call transcript from July 26, 2019 and August 2, 2019 when Ms. Chommany called 911 for assistance. They both advised that given the indicators of agitation, unpredictability and physicality, the ARCC team would not have attended these events unless cleared by general patrol first. There was the possibility that if general patrol had attended and Mr. Chommany had calmed down and engaged with them, general patrol may have requested ARCC to come to provide further assessment.

[102] Where the ARCC team could have made a more significant difference was with respect to proactive services. Follow-up with Ms. Chommany who was struggling with managing Mr. Chommany and his medications is an area where ARCC may potentially have provided benefit in this fact situation.

[103] Statistics regarding the pilot project show a significant impact from the program. The pilot project year end review reports:

- A 29 percent reduction in voluntary mental health presentation.

- A 15 percent reduction in general patrol transports to health care facilities.
- 12 out of 23 clients representing a 10 percent reduction in dispatched calls for service in the 3rd quarter. In the 4th quarter 17 out of 23 clients represent a 10percent reduction in dispatched calls for service.
- A 21 percent reduction in police calls for service among level 5 clients.
- A 49 percent reduction in emergency department presentation among level 5 clients.

[104] It is clear that ARCC can provide very valuable proactive services in situations where an individual is voluntary and cooperative. The ARCC team is not able to respond in person to situations where there are mental health forms representing involuntary admissions, an armed person or active threat, persons in drug psychosis or heavy intoxication, or serious criminal matters not suitable for restorative justice.

[105] Inspector Peters spoke of the need for better resources to enable general patrol officers to have more streamlined access to the health system for people who are brought in involuntarily. She spoke of the limited access to facilities to house people safely while awaiting receipt of psychiatric services. Many times this may involve having a safe place to lodge individuals until such time as they are no longer under the influence of intoxicants. Unfortunately, the present situation is that two officers must remain with the individual until care can be transferred. It is a very inefficient use of police resources. Unfortunately, while I recognise that this is a significant

inefficiency within the system, the issue is beyond the scope of what I will be addressing in this inquest. It will not form part of my recommendations, but I nevertheless mention it to bring some awareness to the issue.

IX. RECOMMENDATIONS TO PREVENT SIMILAR DEATHS IN THE FUTURE

[106] Based on the foregoing review, I make the following recommendations to prevent death from occurring in similar circumstances:

Proactive intervention

[107] **I recommend that all levels of government continue to commit resources towards support for persons living with mental illness**. Mental health is an issue which is pervasive in our society. Dr. Rousseau identified dramatically increased numbers of people in the community with untreated mental illness. Continuing resources are needed to address this significant need.

[108] **I recommend that the City of Winnipeg and Shared Health continue their support and funding for ARCC**. ACCC is an example of a CIT aimed at enhancing police response to mental health calls and providing extra supports not available elsewhere. Proactive resources to assist individuals living with mental illness will ideally mitigate conditions before they become ACE situations.

Target Area 1 – Moderation of Person's Behaviour

[109] **I recommend that WPS review their policy and training on responding to ACE events**. In 2023, WPS in-service training began to include a refresher on ACE incidents. If it does not already, ACE training should include the following:

i. Emphasis on the use of alternative or de-escalation techniques prior to defaulting to physical restraint, including having one lead contact between police and the subject, and use of crisis communication skills.

ii. Education on the significant stress response the subject may be experiencing during an ACE and the potential for a serious adverse cardiac event.

iii. Recognizing that officers are responding in the moment to dynamic and unpredictable situations, there could nevertheless be benefit further instruction on how to restrain and monitor hyperactive agitated individuals. In particular, ACE training should emphasize:

1. Subjects be maintained in the prone position for the minimum amount of time possible;
2. Recognition that having control of the subject does not necessarily require the subject to be compliant; and
3. The need for close observation of the restrained subject with specific protocol to monitor breathing other than mere visual checks.

Target Area 2 – Reduce Gap Time

[110] **I recommend that WPS and WFPS jointly establish a specialized unit specifically trained to respond to agitated chaotic events**. Dispatching both a WPS officer and a medically trained individual with the ability to administer chemical restraint if required would greatly reduce the gap time and transition hyperactive agitated individuals into care sooner.

X. RECOMMENDATIONS WHICH ARISE OUT OF THE MATERIAL CIRCUMSTANCES OF DEATH

[111] I include this section separately as I recognize that the recommendations contained in this section do not specifically relate to the prevention of death in similar circumstances. In my view, however, the jurisdiction of an inquest judge may extend to recommendations which naturally and incidentally arise out of the circumstances of death. In this regard, I cite my sister Judge Krahn's comments from the *Inquest Into the Death of Craig Vincent McDougall* (9 May 2017) (at para 259):

> I recognize that there is a need for an Inquest Judge to carefully monitor the scope of the Inquest and the recommendations that arise from the circumstances of death so that it does not become a roving inquiry into matters of general public concern. But at the same time, there must be sufficient jurisdiction to meaningfully deal with all of the circumstances surrounding the death to "check public imagination" to ensure that government policies are developed that respect human life. This is a context specific inquiry into those matters which are implicated in the death before the Court. The recommendations I have made in this report are meant to prevent deaths in similar circumstances and address the issues which arose naturally out of the material circumstances of death.

[112] In the *McDougall* inquest, Judge Krahn made the following recommendations:

- the WPS "study and consider setting service standards which would set recommended guidelines for how long witnesses must wait in the police station before their statements are taken" (at para 85) ; and
- the "rights of a witness should be clearly explained to the witness throughout their interaction with the police, including that they are free to go or stay, that there will be no consequence to them if they choose to leave and they have no legal obligation to give a statement" (at para 180).

[113] In this proceeding, inquest counsel suggested the following recommendation:

> With respect to the circumstances in which Mr. Chommany's death occurred, the Court should find that the failure of the WPS to communicate Viengxay Chommany's condition to Sam Chommany was a significant oversight. Ms. Chommany ought to have been advised that her husband had been taken to St. Boniface Hospital as a result of what police believed to be a critical incident. Where a critical incident has occurred in which the complainant is the next of kin, the notification of next of kin should precede the taking of a formal statement from them, subject to the seriousness and urgency of the criminal incident. This would permit the next of kin to make an informed decision as to whether they wish to provide a statement then or whether they wish to attend the hospital to be with their relative.

[114] I agree with this recommendation. Will-say statements were filed from the WPS officers who were involved with Ms. Chommany following the incident, namely Sgt. Dean Rochon, D/Sgt. Michael Pimentel, Cst. Aaron Blouw and Cst. David Patton.

[115] Given the passage of time, their recollections are limited. Each of the officers confirmed that they did not give or receive instructions to withhold Mr. Chommany's medical information from his wife.

[116] At around the time of the incident, Cst. Patton prepared notes and narrative. His narrative report indicates that he and Cst. Blouw went to the Chommany residence at sometime after 01:06 and spoke with Ms. Chommany there. She was questioned about the events and she provided details about what had occurred. They were then directed by P/Sgt. Rochon to transport her to East District station to await further direction. At shortly after 02:01 she was brought to East District station and placed alone in a room. The crew met with A/Sgt. Pimentel and P/Sgt. Rochon and they were directed to obtain a video statement regarding the incident. The crew then met with Ms. Chommany and requested that she provide a video statement, to which she agreed. The videotaped statement was obtained between 03:03 and 03:27. At the conclusion of the statement, she was taken to St. Boniface Hospital, where nursing staff placed her in a private waiting room. N406 (WPS officers) were present at the hospital with Mr. Chommany and were notified of Ms. Chommany's presence.

[117] While all officers state that there was no specific instruction to withhold medical information from Ms. Chommany, it is nevertheless clear that there was a systemic failure in the handling of this citizen. Ms. Chommany should have been informed that her husband was being transported to the hospital in critical condition before being asked to go down to the station and made to wait to provide a witness

statement. She did not know what was happening nor what options were available to her. Her rights as a witness should have been explained clearly to her.

[118] The potential interests of the witness do not appear to have been contemplated nor considered by any of the officers involved with Ms. Chommany. While police did not intentionally withhold information, they also did not appear to address their minds to how to deal with Ms. Chommany following the critical incident. The WPS has a critical incident protocol for determining whether the Independent Investigation Unit will be attending, but I did not hear any evidence on procedure with respect to witnesses. A protocol or recommended guidelines setting out best practices as it relates to next of kin witnesses would be beneficial.

[119] **I recommend that the WPS study and consider establishing a protocol or recommended guidelines for handling next of kin witnesses in critical incidents**.

XI. CONCLUSION

[120] I want to again express my deepest condolences to the friends and family of Viengxay Chommany. Ms. Chommany has been through much, and I wish her the best in moving forward from this terrible loss. I hope that through the process of this inquest, she and her family have gained some insight into what happened, and that my recommendations will someday assist in preventing another untimely death.

[121] My thanks go to all counsel for their organized and responsive submissions, and to the witnesses for their contributions in helping us to understand how we might do things better going forward.

[122] I respectfully conclude this report on October 22, 2024, at the City of Winnipeg, in the Province of Manitoba.

Original signed by Judge Choy

CHOY, P.J.

MANITOBA

THE FATALITY INQUIRIES ACT

REPORTED BY PROVINCIAL COURT JUDGE ON INQUEST

RESPECTING THE DEATH OF: Viengxay Chommany

APPENDIX "A" – WITNESS LIST

1. Dr. John Younes
2. Ratsamy Chommany
3. Constable Kevin Kiziak
4. Patrol Sergeant Dennis Robert
5. Constable William Clark
6. Constable Jessica Jones
7. Adam Stubbe
8. Matthew Verhaeghe
9. Tyler Woloshyn
10. Trevor Mutual
11. Derek Stasiuk
12. Sergeant Kelly Keith
13. Dr. Skye Rousseau
14. Danielle Svenne
15. Inspector Helen Peters

MANITOBA

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APPENDIX "B" – EXHIBIT LIST

Exhibit No.	Description
1.	Inquest Binder
1A.	Electronic Version of Inquest Binder
2.	History and Physical Document Requested by Diane Arksey
3.	Shared Health Record Binder(s)
4.	Photograph of Viengxay Chommany
5.	Copy of Constable Kiziak's Notes
6.	Transcript of Police Radio Communications
7.	CAT History Document
8.	EMS Patient Care Report
9.	Transcript of Trevor Mutual's IIU Interview
10.	Transcript of 911 Call from August 2nd, 2019
11.	Mobile Crisis Service Screen
12.	Will-Say Statements of: Cst. A. Blouw; D/Sgt. M. Pimentel; Cst. D. Patton and Sgt. D. Rochon