Release Date: July 14, 2005

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***

AND IN THE MATTER OF: **LAURA LEE DRAPER, DECEASED**
(DATE OF DEATH: FEBRUARY 23, 2002)

AND IN THE MATTER OF: **ARTHUR RANDY GILL, DECEASED**
(DATE OF DEATH: FEBRUARY 10, 2002)

Report on Inquest and Recommendations of
The Honourable Judge Glenn D. Joyal
Issued this 11th day of July 2005

APPEARANCES:

Mr. H. Neil Peterson, Counsel to the Inquest
Ms. Kim Carswell, Counsel for the Winnipeg Police Service

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***

AND IN THE MATTER OF: **LAURA LEE DRAPER, DECEASED**
(DATE OF DEATH: FEBRUARY 23, 2002)

AND IN THE MATTER OF: **ARTHUR RANDY GILL, DECEASED**
(DATE OF DEATH: FEBRUARY 10, 2002)

TABLE OF CONTENTS

I. INTRODUCTION

A. Background to Deaths of Laura Lee Draper and Arthur Randy Gill

[1] The office of Chief Medical Examiner concluded its initial review into the death of Laura Lee Draper, age 39 years, of Winnipeg MB, at St. Boniface General Hospital on February 23, 2002.

[2] Their investigation revealed that on February 23, 2002, shortly after returning home, Ms. Draper ran outside without a coat, behaving in an agitated, disorderly manner. She was subsequently admitted into a residence after telling the homeowner that someone was trying to kill her. The Winnipeg Police were called. Upon arriving at the scene, Ms. Draper, whose behaviour had become more erratic and violent, was being restrained by the homeowners. Ms. Draper was apprehended by the police, but suffered a cardiac arrest before the ambulance arrived. Despite resuscitation efforts, Ms. Draper sustained anoxic brain injury and was declared brain dead. An autopsy showed she died as a result of cocaine use.

[3] The office of the Chief Medical Examiner concluded its initial review into the death of Arthur Randy Gill.

[4] Their investigation revealed that Mr. Gill, age 45 years, of Winnipeg MB, died at the Health Sciences Centre on February 10, 2002 after he became unresponsive while members of the Winnipeg Police Service were attempting to subdue him and place him in an ambulance. Prior to his apprehension, Mr. Gill, who was observed to be behaving in a bizarre

fashion, had hurled himself through a plate glass window of a shop on Arlington Street. An autopsy confirmed Mr. Gill died as a result of agitated or excitable delirium due to cocaine use.

B. Holding of the Inquest

[5] The Fatalities Inquiries regarding the deaths of Laura Lee Draper and Arthur Randy Gill were held on January 17, 18 and 19, 2005. Because of the similar causes of death (excitable delirium caused by cocaine use) and the similar issues surrounding those deaths, the inquests were held on consecutive days, with the Court receiving certain expert opinion (the testimony of Dr. Wesley Palatnick and Sergeant B. Bishop) as applicable to both inquiries.

[6] The evidence surrounding the death of Laura Lee Draper involved six witnesses, most of whom were professionals in the area of public safety (police officers) or emergency response (first responders, paramedics, ambulance attendants).

[7] The evidence surrounding the death of Arthur Randy Gill involved six witnesses, whose nature was similar to those adduced in respect of the death of Laura Lee Draper.

[8] The focus of most of the above witnesses related to their initial observations of both Ms. Draper and Mr. Gill and their own or their colleagues' response to two rather violent and volatile situations. In the case of the police witnesses, their initial attendance and response related

to what they had been told were potential crimes involving individuals who were behaving in an erratic, uncontrolled and seemingly illegal fashion.

[9] The emergency responses to both Ms. Draper and Mr. Gill, involved an initial and necessary form of physical restraint which very soon into the incidents, escalated into emergency care and treatment.

[10] The fundamental focus of the evidence at the inquiries respecting Ms. Draper and Mr. Gill, involved an examination of the emergency response, the promptness with which the state of excitable delirium was identified, and the positioning used in the initial restraint and eventual treatment and care of both deceased.

[11] As the medical evidence clearly demonstrated, both Ms. Draper and Mr. Gill died while in a state of excitable delirium. According to the medical evidence (which I will review later in greater detail), while the causes or inciting factors which lead to a state of excitable delirium are not mysterious, its occurrence or manifestation remains nonetheless rare. Once an individual has reached this point of physiological agitation and trauma (as a result of cocaine “binging” over an intense period of time) he or she is nothing less than a “ticking time bomb”. Once in a state of excitable delirium, individuals pose an immediate threat to both themselves and others. In light of the complicated diagnostic, medical and public safety issues surrounding each case, the presentation of such emergencies pose what can only be characterized as one of the most difficult challenges facing police officers, first responders and paramedics.

[12] Given the fortunate rarity of such cases in Winnipeg, the two deaths which occurred coincidentally within two weeks of each other (February 10, 2002; February 23, 2002) represent both a reminder and opportunity. As rare as these cases are, the relevant emergency agencies are reminded that in a society where cocaine use inevitably occurs, the horrific scenario of excitable or agitated delirium is always possible. With such a possibility always present, the tragic deaths of Ms. Draper and Mr. Gill provide an opportunity to re-examine the emergency responses in an effort to determine whether anything could have been done differently and whether such different action could prevent this type of death in the future.

[13] The mandate of the Provincial Court Judge sitting in an inquest such as this reduces to the basic but important task of preparing a written report to the Minister. The report must furnish information concerning when, where and by what means the deceased died. Additionally, the report need address the cause of death, the material circumstances of the death, as well as any recommended changes. Those recommendations can be in respect of the programs, policies and/or practices of the government and any relevant public agencies or institutions when the judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that occurred in the subject inquest.

[14] The mandate of the judge sitting at an inquest requires him or her to make any such relevant recommendations without making stark determinations that could “point the finger” at a person or institution in a

way that could reasonably suggest that that person or institution is the culpable party in respect of the death that is the subject of the inquest. As will become clear from my report, I am making no such findings that would attribute guilt. Even if such determinations were part of my mandate, the material circumstances surrounding the deaths of both Ms. Draper and Mr. Gill are such that no such attributions of culpability would be justified or warranted. Indeed, the tragedy of both deaths is heightened by the sad reality that by the time emergency intervention was required, the cocaine ingestion by both individuals was such that the bomb that is “excitable delirium” had already started to tick. Based on the evidence at this inquest, nothing that anyone did or did not do to Ms. Draper or Mr. Gill triggered that bomb. The helplessness that surrounds that proposition not only defines the tone of the evidence, but regrettably, it also limits the extent to which this court is able to make constructive recommendations to avoid such deaths in the future.

[15] Before I proceed with a specific review of the relevant evidence relating to the deaths of Ms. Draper and Mr. Gill, I wish first to review the evidence of Dr. Palatnick and Sergeant Bishop. The evidence of these witnesses constitute in my view, expert opinion in relation to the medical and public safety issues that present when dealing with an individual in a state of “excitable delirium”. The respective testimony of Dr. Palatnick and Sergeant Bishop provides important background and many useful reference points for the issues that I have identified as requiring my attention.

II. BACKGROUND EXPERTISE: MEDICAL AND PUBLIC SAFETY POINTS OF REFERENCE

A. Dr. W. Palatnick

[16] Dr. Palatnick has been the Department Head of Emergency Medicine at the Health Sciences Centre since 1997. His curriculum vitae marked as Exhibit "11" provided more than the necessary foundation to establish the background and expertise for the opinion evidence he gave concerning the nature, diagnosis, cause and emergency treatment of excitable delirium.

[17] Dr. Palatnick described excitable or agitated delirium as that physical state (arising from cocaine "binging") which results in a visible euphoria, agitation, aggressiveness and oftentimes, paranoia. The physiological effects on the heart and the elevation of an individual's blood pressure create a situation where an individual who is suffering from excitable delirium, is quite literally "a ticking time bomb". In such a state, death can happen abruptly (sudden cardiac arrest) after any sort of struggle or physical exertion. By definition, once an individual is in such a state, he or she is at risk no matter what is done. While the mortality rate is very high, Dr. Palatnick did stipulate that there are certain things that can be done to minimize that risk.

[18] Death from excitable delirium is "well described" but according to Dr. Palatnick, relatively rare. It is caused when individuals take cocaine in a "binging fashion" for a number of days. In other words, excitable delirium is usually the result of "a sort of bender" where cocaine consumption takes place in an intense manner over a particular period of time. Indeed, the

quantities of cocaine ingested need not be particularly high. More relevant in the cause of excitable delirium, is the frequency and consistency of the use over a contracted period of time (for example, over a period of three or four days, or in some cases, one day). In support of this proposition, Dr. Palatnick pointed to the autopsy reports of both Ms. Draper and Mr. Gill. In the case of both deceased, Dr. Palatnick identifies the fact that the levels of cocaine found in each was not particularly high.

[19] One of the difficulties in properly and adequately treating an individual in this state, is that they manifest a level of aggressiveness and paranoia that precludes the necessary and delicate medical care required. An individual in this state has his or her ability to listen and speak seriously compromised.

[20] The basic treatment in the emergency room and on scene involves verifying a pulse and all “vitals”. Thereafter, the next most challenging aspect of treatment relates to how one deals with the state of agitation. The state of agitation itself can create some of the additional problems an individual faces because of the accompanying increase in heart rate and blood pressure. Adequately diagnosing and identifying the manifestations of excitable delirium (agitation, paranoia and aggressiveness) is a necessary first step in ensuring that the subsequent precautionary measures are taken with adequate care and speed.

[21] In reviewing Dr. Palatnick's evidence, I note the identification of four particularly important points that he suggests need be remembered when dealing with any case of excitable delirium.

1. Protect the person, yourself and others while not agitating that person unnecessarily;

2. To the extent possible (and Dr. Palatnick 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.

[22] Again, it is important to stress that Dr. Palatnick stipulated that in the context of an emergency situation, a strict adherence to the above four points is not always possible. The mere fact that the individual presents as agitated, aggressive and generally out of control (because of the increased adrenalin he or she can exhibit uncharacteristic strength) usually necessitates a level of force and restraint irreconcilable with the care ideally required.

[23] It should be noted that Dr. Palatnick was a member of the Winnipeg Fire Paramedical Council which in 1997 and 1998, formulated a new protocol for dealing with the medical and public safety emergencies that surround cases of excitable delirium. Mindful of his role as a participant in that council as well as his participation in the formulation of that protocol,

Dr. Palatnick was asked to review Exhibit “8” in these proceedings. That exhibit consists of the select pages from the Winnipeg Police Service policy manual respecting excitable delirium. That policy was enacted in 1998 and is required reading for all City of Winnipeg police officers. After his review of that policy, Dr. Palatnick provided his endorsement and indeed, expressed himself satisfied that it corresponds to what he identified are the important points that need be remembered when dealing with such cases.

B. Staff Sergeant B. Bishop

[24] This witness is currently the Staff Sergeant at Division 11 of the Winnipeg Police Service.

[25] Staff Sergeant Bishop first became interested in the public safety implications of excitable delirium at the end of 1996. At that time, he was working in the Winnipeg City police training division. It was also at that time that he began to read more widely on the subject. He was specifically impressed by a report that he read from the Ontario Chief Medical Examiner. That Report and its focus contrasted with what Sergeant Bishop described was a more complicated Winnipeg Police Service policy.

[26] As Staff Sergeant Bishop became more interested and involved in the subject of excitable delirium, he became involved in the Medical Advisory Committee whose advice and consultation was directed to (amongst other agencies) the police, the fire/paramedics, and ambulance service. It was during this period of time that Staff Sergeant Bishop continued to do a considerable amount of research. Indeed, it was at this same time, that he

worked with the then head of the Emergency Department at the St. Boniface Hospital, Dr. Ira Ripstein. That work with Dr. Ripstein and others involved with the Medical Advisory Committee, culminated in a now two page document which constitutes the part of the Winnipeg Police Service policy manual dealing with excitable delirium. Those pages of the manual (marked as Exhibit "8") are according to Staff Sergeant Bishop, more concise then the old policy and they more properly identify excitable delirium as a medical emergency which can lead to sudden death.

[27] Staff Sergeant Bishop testified that this new policy was originally received by the Chief and his staff and initially came out as an Order No. 34/1998 (issued September 18, 1998) and would have been sent out to all divisions along with an accompanying training video. It was explained that any major change in policy, is usually identified as a "General Order", a designation which signifies that (pursuant to Winnipeg Police Service regulations) all officers must read the Order and in this case, see the accompanying video.

[28] Staff Sergeant Bishop explained that the accompanying video (marked as exhibit 24 in these proceedings) was presented as a "role call" video. That means that at the beginning of every shift (subsequent to the publication of the General Order) there is a "role call" by the officer in charge at which time the officers on that shift (in whatever division) have brought to their attention, the existence of a new policy and in this case the explanatory video. When something such as a new or modified policy is presented (as Sergeant Bishop said the video was) it is understood that

that presentation usually occurs at the role call. So in this case, if someone would have missed the role call and not had an opportunity to see the video, it would have been understood that an obligation existed to ensure that the video would have been watched within 30 days.

[29] In addition to the initial publication of the General Order (and its presentation as policy) and the circulation of the role call video, the subject of excitable delirium is now part of a police officer's first aid training. That is, every officer gets one day of such training every two years. In the course of that training the subject of excitable delirium is addressed.

[30] Staff Sergeant Bishop also indicated that there is currently a proposal that has gone forward which would see the subject of excitable delirium addressed in the context of a one full day "use of force" certification training session. While this proposal is currently in development, if it is accepted, the training would quite obviously attempt to more specifically address how in the case of excitable delirium, use of force measures could be utilized, adapted or modified.

[31] The attempt to specifically address the need to reconcile the medical issues with the "use of force" issues seems particularly important and laudable. In that regard, Staff Sergeant Bishop provided important evidence concerning the complicated challenges facing police officers when dealing with someone suffering from excitable delirium. As Staff Sergeant Bishop's evidence suggests (and as reflected in the circumstances surrounding the deaths of both Ms. Draper and Mr. Gill) seldom if ever are police officers

made aware prior to their arrival that they are dealing with a situation of excitable delirium. In most cases, police officers are called as a result of erratic, aggressive and paranoid behaviour which at the very least has caused a disturbance. Accordingly, when police officers normally arrive on scene of an individual suffering from excitable delirium, those police officers are responding to what they believe is a crime or a potential crime. Unfortunately and all too quickly, the officers' attendance to that so-called crime scene is marked by a transition to a medical emergency. It is a medical emergency which as Dr. Palatnick indicated, involves an individual who at any minute, can succumb to sudden cardiac arrest. The immense challenge for police officers, is to promptly identify cases of excitable delirium and thereafter (mindful of the always present medical dangers) to calibrate the necessary measures of restraint.

[32] The earlier mentioned policy and video provide instruction on how to recognize excitable delirium and how best to respond in ways that ensure not only the safety of the suspects and by-standers, 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 urges 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).

[33] Staff Sergeant Bishop asserted confidently during his testimony, that either because of the role call or the 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.

[34] Staff Sergeant Bishop makes the important point that the judgement calls required of a police officer when dealing with excitable delirium are many and difficult. Something as basic as the initial diagnosis cannot be confirmed until death. Nevertheless, police officers are expected to act in ways which balance the public safety priorities with what are the immediate possible dangers to the suspect. The nature of the medical emergency is such that death can occur at any time, thus making immediate treatment essential. That reality implies that police intervention must occur quickly. Paradoxically, the problem with such intervention is that it often runs up against strong and violent resistance. The resistance in turn gives rise to police restraint, a response which in itself, constitutes a risk to the suspect.

III. THE EVIDENCE AT THE INQUEST OF LAURA LEE DRAPER

[35] As earlier mentioned, six witnesses gave *viva voce* evidence respecting their involvement in the events leading to the death of Laura Lee Draper. In addition, I was provided and I have carefully read the written

statements of Norman Cannon, Diane Cannon, Grant Nagam and Douglas Mann. Those statements have been marked as Exhibits “1” through “4”.

[36] The following is a brief summary and focus of the evidence of those witnesses who appeared and provided testimony.

A. Detective Sergeant Todoruk

[37] Detective Sergeant Todoruk testified as to his involvement as one of the first officers on the scene in response to a reportedly “uncontrolled” woman who presented to the front door of 39 Paddington saying “someone was trying to kill her”. Detective Sergeant Todoruk testified as to how it was that he initially attempted to deal with her and how police “back up” and emergency medical care (first responders and paramedics) soon took over. Like most if not all of the other police witnesses, Detective Sergeant Todoruk realized immediately after having arrived, that he was dealing with a medical emergency and not a criminal investigation.

B. Constable Kondrat and Constable Kollusky

[38] Constable Kondrat testified as to his arrival at the scene with his partner Constable Kollusky and how they found Detective Sergeant Todoruk present with Ms. Draper. They took over from Todoruk and made attempts to stabilize and restrain Ms. Draper in a manner appropriate to Constable Kollusky’s fairly early diagnosis that Ms. Draper was suffering from excitable delirium.

C. Rick Haywood

[39] Mr. Haywood gave evidence pursuant to his position as member of the Winnipeg Paramedic Service. He testified that he holds the top level for someone working in his field and is capable of providing treatment in respect of “advance life support”.

[40] Mr. Haywood testified that he attended to the residence at 39 Paddington after having received a call from dispatch. He was sent to assist a paramedic crew already on scene. Mr. Haywood was working by himself. While he was on route to the scene, the nature of the call was upgraded to one of cardiac arrest. When he arrived at the house in question, the first responders were already on the scene. Mr. Haywood proceeded to “intubate” (inserting a tube down Ms. Draper’s throat to assist her breathing). This was done in an attempt to “ventilate”. According to Mr. Haywood there was no palpable pulse or respiratory effect. In addition, notwithstanding the drugs administered (Epinepheram and Narkam) the heart rate remained extremely light and on the whole, Ms. Draper remained unresponsive. Despite additional efforts to stabilize Ms. Draper in the ambulance, she remained totally unresponsive. At the hospital, she appeared critical, “almost terminal”.

D. Gord Carlowe

[41] Mr. Carlowe gave evidence as a fire captain with the Winnipeg Fire Service. He was dispatched from Station 26 (Dakota and Ward) not far from the residence in question. Mr. Carlowe is neither a first responder nor

a paramedic. Accordingly, when he arrives at a scene, his role is to stabilize until the paramedics arrive.

[42] Mr. Carlowe testified that when he first arrived, he found police officers Todoruk, Kondrat and Kollusky. He described how it was necessary for Ms. Draper to be restrained and how exactly that restraint took place.

E. Dean Robinson

[43] Mr. Robinson gave evidence as a member of the Winnipeg Fire Service. He is a first responder. That status means he is capable of administering some primary medical care at the scene of an emergency. The purpose of a first responder is to provide a patient with the best available care as soon as possible.

[44] Mr. Robinson gave evidence describing how, when he arrived at the scene, he observed what the police officers were required to do in order to restrain Ms. Draper as she thrashed about. Based upon her behaviour, Mr. Robinson was not sure whether or not Ms. Draper's reaction was drug (excitable delirium) or diabetic related.

IV. ISSUES TO BE ADDRESSED

[45] Based upon the expert evidence of Dr. Palatnick and Staff Sergeant Bishop and in light of the circumstances surrounding the two deaths (circumstances which are rather typical of situations involving excitable delirium), the key issues at the inquest reduce to the following:

1. The question of identifying and diagnosing excitable delirium.

   Did the emergency responders identify and/or diagnose the particular emergency with adequate speed?

2. The question of restraint and positioning.

   In light of the public safety risks imposed by the deceased, was the necessary restraint achieved with proper care being paid to the positioning of the deceased?

3. The question of the sudden and rapid physical decline of the deceased.

   Once having lapsed into distress, could the emergency responders have done anything different to save the deceased's life?

1. The question of identifying and diagnosing excitable delirium.

Did the emergency responders identify and/or diagnose the particular emergency with adequate speed?

[46] As often happens in cases of excitable delirium, the deceased Draper presented herself to civilians in a situation which caused concern and even fear. The residents (the Cannons) of 39 Paddington were confronted with a woman at their front door who was described as hysterical, paranoid and out of control. The residents who called the police, not surprisingly made no mention of excitable delirium. Their concern was for their own safety, and the safety of Ms. Draper.

[47] The arrival of the police occurred in the context of what the police believed was a probable criminal investigation into something that happened or was about to happen. After further exposure to Ms. Draper on scene, each officer (to varying degrees) became increasingly aware of the seriousness of the medical emergency and specifically, the possibility that this was a situation of excitable delirium.

[48] When Detective Sergeant Todoruk first noticed Ms. Draper being held on the lap of one of the homeowners, he noted what appeared to be froth coming from the sides of her mouth. Accrording to Detective Sergeant Todoruk, she was incomprehensible and appeared to be non-comprehending. Because of Todoruk's safety concerns in the face of her continuing resistance, he decided to handcuff Ms. Draper.

[49] A very short time after his arrival, Constable Kondrat and Constable Kollusky arrived and according to Staff Sergeant Todoruk, one of the first phrases out of Kondrat's mouth was "excitable delirium". It was a diagnosis which Todoruk quickly came to agree with based upon what he confirms was at the time, his most recent police first aid update, his observation of the video and as well, his recent discussions of a similar case (that of Mr. Gill) that had occurred just two weeks prior to his involvement with Ms. Draper.

[50] It was after Constable Kondrat's identification of excitable delirium that an ambulance was called. It arrived approximately 8 to 9 minutes later.

[51] The officers relatively early identification of a possible case of excitable delirium was passed on to the others who attended the scene: the paramedic (Mr. Haywood), the fire captain (Gord Corlowe) and the first responder (Dean Robinson).

[52] As in the case of the police, everyone seemed to govern their measures of restraint and treatment, mindful of the medical emergency everyone acknowledged. In the circumstances, there was nothing in the speed of the diagnosis or the identification of the case of excitable delirium that could be considered inappropriately slow. On the contrary, it would appear that the available information permitted the attending police officers to observe and confirm the early onset of the medical emergency. Accordingly, the necessary care and attention that such a medical emergency required was provided. The rather rapid deterioration in Ms. Draper's condition was identified and associated with excitable delirium. To the extent possible, given the strong resistance by Ms. Draper, the transition from a criminal investigation to a medical emergency went as smoothly as can be expected.

2. The question of restraint and positioning.

In light of the public safety risks imposed by the deceased, was the necessary restraint achieved with proper care being paid to the positioning of the deceased?

[53] The initial dispatch to the police signaled what could have been a dangerous situation at the residence of 39 Paddington. The call that the

police officers received, was clearly such so as to cause them to have concerns for safety. Indeed, when Detective Sergeant Todoruk arrived at 39 Paddington, those concerns were confirmed when he observed Ms. Draper, who was still out of control and trying to break free from one of the homeowners who was attempting to restrain her. Based upon his observations of Ms. Draper and his concerns for the safety of the homeowners (and their children who were also present), as well as his concerns for the safety of Ms. Draper herself, Detective Sergeant Todoruk felt he had no choice but to handcuff Ms. Draper.

[54] Because of the manner in which Ms. Draper continued to struggle and refused to sit up, Todoruk was forced to place her on her stomach. At one point, Todoruk was required to straddle her legs. In doing so, he at no point put pressure on her back and even while over her legs, he stressed he was not sitting but merely straddling.

[55] When Constables Kondrat and Kollusky arrived, they observed Ms. Draper in this position as she continued to scream and rant “like a rabid animal”.

[56] All of the officers at various points testified to their efforts at trying to sit Ms. Draper up but because of her continuing resistance and struggling, “she continued to slide down”. Again, the officers were forced to place her on her stomach.

[57] Once the first responders and paramedic arrived and after having consulted with them, the police removed the handcuffs from Ms. Draper. It

was after the handcuffs were taken off that Ms. Draper's "distress" started to intensify.

[58] All of the witnesses, who observed the police restraint, characterized it in one way or another as having been necessary and in response to Ms. Draper's violent struggling. All of the witnesses in a position to see, confirmed that none of that restraint, even when Ms. Draper was on her stomach, involved putting pressure on her back or on any other portion of her body such so as to cause a blockage in her air ways.

[59] It is clear from the evidence, that the police officers early identification of the situation as a medical emergency caused them to take all the necessary precautions in their "use of force". Insofar as they were required to place Ms. Draper in a less than ideal position (on her stomach), such a position was as a result of Ms. Draper's uncontrolled state and her seeming unwillingness to sit up each time she was given an opportunity to do so.

[60] Based on the evidence and given the context of the fast moving and developing circumstances "on scene", the police officers ought not to be criticized for their use of restraining measures (temporarily placing Ms. Draper on her stomach) on which Ms. Draper's own violent struggles forced them to rely.

3. The question of the sudden and rapid physical decline of the deceased.

Once having lapsed into distress, could the emergency responders have done anything different to save the deceased's life?

[61] The first general signs of the potential for a medical emergency were properly identified by the first three officers (Todoruk, Kondrat and Kollusky) on the scene. The first specific signs of serious distress occurred when Constable Kondrat and Constable Kollusky were attending to Ms. Draper and they noticed her eyes begin to role in the back of her head. They immediately advised Detective Sergeant Todoruk to put a "rush" on the already requested ambulance. The officers believed she was going into cardiac arrest.

[62] When Rick Haywood of the Winnipeg Paramedic Service arrived some 8 to 12 minutes after the first police officers, he found a paramedic crew already on scene administering to Ms. Draper who by that time was lying on the stretcher. It should be noted that Mr. Haywood's attendance was requested because of his "upgraded emergency credentials" and his ability to administer certain medications that other paramedics cannot.

[63] The general rapid attention of the paramedics and Mr. Haywood's prompt attempts at intubation (and his administering of what he believed were the required drugs) constitute in my view the best paramedical efforts in the circumstances to save Ms. Draper's life. At no point in time was anything done or not done by the police, the paramedics or first

responders, which could be viewed as inconsistent with the existing policy or the general guidelines discussed by Dr. Palatnick

V. CONCLUSIONS RESPECTING THE DEATH OF LAURA LEE DRAPER

[64] In reviewing all of the testimony and the exhibits, I can find nothing in the police conduct that was or could be called in the circumstances, inappropriate or untoward. Neither can I find anything in the medical emergency treatment of Ms. Draper that was unnecessarily slow, inappropriate or inadequate.

[65] Ms. Draper's violent, paranoid and uncontrolled struggles had begun before the police arrived at 39 Paddington. Once on scene in what initially presented as a public safety threat, the police were required to intervene. At some point during that necessary intervention, the ticking bomb which is excitable delirium, detonated. Based upon the expert evidence of Dr. Palatnick, it is my view that despite the prompt and responsible emergency medical care Ms. Draper received, nothing could have been done to save Ms. Draper from the rapid and almost inevitable physical explosion that accompanies the state of excitable delirium.

VI. THE EVIDENCE AT THE INQUEST OF ARTHUR RANDY GILL

[66] As earlier mentioned, six witnesses gave *viva voce* evidence respecting their involvement in the events leading to the death of Arthur Randy Gill. In addition, I was provided and I have carefully read the written

statements of Roy Harriott, Leslie Tazumi, Wade Mcdonald, Grant Hansen and Adam Kosarych. Those statements have been marked Exhibits “14”, “16”, “17”, “18”, and “19” respectively.

[67] The following is a brief summary and focus of the evidence of those witnesses who appeared and provided testimony.

A. Constable Senkowski and Constable Barker

[68] Constables Senkowski and Barker testified to their involvement as the first officers on the scene in response to a call about a very large man, half undressed, screaming and standing in the middle of Arlington, while bleeding from the arm. The man was standing in front of the broken window of Don Vito’s Autobody. Like the other officers who attended, Constables Senkowski and Barker testified as to how they arrived at the scene believing that they were responding to a possible break and enter and/or an assault.

[69] These witnesses gave evidence respecting their initial observations and conclusions concerning what they believed would have been Mr. Gill’s drug induced state.

[70] They described how it was that Mr. Gill was initially approached, handcuffed and how Mr. Gill eventually became very resistant and violent. The witnesses described the eventual attendance of the paramedics and everyone’s efforts to initially place the resisting and struggling Mr. Gill onto a stretcher.

[71] Constables Senkowski and Barker also provided testimony concerning that failed attempt (to initially put Mr. Gill on the stretcher) and the increased efforts that had to be taken to restrain Mr. Gill for his and everyone else's protection.

[72] These officers were present when, for a second time, Mr. Gill was placed on a stretcher, put in the ambulance and at which time, the medical emergency became apparent.

B. Kyle Young and Andrew Gatien

[73] These two friends testified as to having been together in the early morning hours of the day in question. Mr. Gatien had been picked up at his place of employment (the Palomino Club) by Mr. Young after which they proceeded to drive around in Mr. Young's new truck. At one point, they found themselves driving on Arlington when they noticed something that caught their attention. Directly in front of Don Vito's Autobody, they noticed a broken window, and a very large individual with his pants pulled down. The man appeared to be bleeding. The individual (later identified as Mr. Gill) was yelling that "someone was trying to kill him" and he wanted Gatien and Young to help him.

[74] After having turned the vehicle around, these two witnesses testified that they called 911 for police attendance.

[75] Upon the arrival of the police, these witnesses testified that they observed the police handcuff Mr. Gill after which he appeared to sit (without

incident) on the street. The witnesses say they remained on the scene for approximately 10 minutes. By the time they left, they had observed the increasingly erratic and struggling behaviour of Mr. Gill and how that behaviour required greater restraint on the part of the police.

C. Constable Bettans

[76] This witness testified that he arrived shortly after Constables Senkowski and Barker. It appeared that Senkowski and Barker already had the scene under control. Mr. Gill was seated and handcuffed on the street. Constable Bettans noted that Mr. Gill appeared to be “sweating”. He found this odd as it was mid-winter. Bettans also noticed that no one seemed able to communicate with Mr. Gill.

[77] Constable Bettans gave testimony which confirmed the observations of the other officers and civilians. At one point in his testimony, Constable Bettans allowed that: “had they known that this was a case of excitable delirium, they may have done certain things differently.”

D. Tom Wallace

[78] Mr. Wallace gave evidence pursuant to his position as a member of the Winnipeg Paramedic Service. He testified that on the morning in question, he was working with his partner, Leslie Tazumi.

[79] When this paramedic team arrived on the scene, they saw the police vehicles already present and noticed that the accused was half undressed

and appeared to be bleeding. By the time Mr. Wallace's paramedic unit had arrived, he indicated that Mr. Gill was already fairly combative.

[80] Because of the cold and Mr. Gill's state of undress, the paramedics wanted to get Mr. Gill into the ambulance as soon as possible. It was with that goal in mind that Mr. Wallace's partner went to fetch the stretcher. During this period of time, Mr. Wallace noticed that the accused continued to yell in a somewhat paranoid fashion: "Just do me . . . I know you're going to do me . . . shoot me, shoot me".

[81] Mr. Wallace's first observations of Mr. Gill was that there were no obvious obstructions to his airways or breathing.

[82] Mr. Tazumi returned with the stretcher at which time the paramedics and three police officers attempted to place Mr. Gill onto the stretcher. Mr. Wallace testified that Mr. Gill was so combative in his struggles that it became impossible to place him on the stretcher and in fact, just before rolling off the stretcher, he (Wallace) was kicked in the head by Mr. Gill.

[83] Mr. Wallace recalled that after that initial violent struggle and in an attempt to get Mr. Gill on the stretcher, the police felt obliged (a judgement about which Mr. Wallace was in agreement) to call for shackles which were intended to further assist in the restraint and ultimate transfer of Mr. Gill to an ambulance.

[84] It was this witness who gave testimony concerning the steps that were taken to save Mr. Gill at that point in time when the serious medical emergency became obvious.

VII ISSUES TO BE ADDRESSED

1. The question of identifying and diagnosing excitable delirium.

Did the emergency responders identify and/or diagnose the particular emergency with adequate speed?

[85] The initial observations of Mr. Gill by Kyle Young and Andrew Gatien caused them to believe that he was either drunk or on drugs. The fact that he was bleeding, his inappropriate manner of dress (it was February and Mr. Gill was not wearing a jacket and his pants were pulled down), his incoherent yelling, his cries for help and claims that someone was going to kill him, caused those same civilians to believe that Mr. Gill may have been beaten up.

[86] Accordingly, the calls that the police initially received suggested that the incident involved a possible assault and/or a break and enter (in progress) of the autobody shop on Arlington in front of which the described incident was taking place.

[87] The officers' initial observations at the scene (the broken window at Don Vito's Autobody and the strange behaviour of Mr. Gill) did not change their view that this was a criminal investigation. Although the civilians, the

police and the responding paramedics all believed that Mr. Gill's behaviour was consistent with someone on drugs, no specific or general mention was ever made respecting that this was a possible case of excitable delirium. It is interesting to note that in his written statement (Exhibit "16") the paramedic Leslie Tazumi recalled one police officer at the scene observing that Mr. Gill was "foaming at the mouth" and was according to that officer, acting like someone who had taken an overdose of cocaine. Notwithstanding that observation, excitable delirium and its dangers were never specifically identified or diagnosed at the scene.

2. The question of restraint and positioning.

In light of the public safety risks imposed by the deceased, was the necessary restraint achieved with proper care being paid to the positioning of the deceased?

[88] Even though there was no formal identification or diagnosis of excitable delirium at the scene, everyone who observed or had contact with Mr. Gill, seemed to recognize the likelihood of drug use. At the very least, that fact (that Mr. Gill was "high on drugs") seemed to trigger an additional caution and care in respect of how the police and paramedics dealt with what was Mr. Gill's bizarre behaviour.

[89] One of the reasons for which Mr. Gill was initially handcuffed (without incident) was not so much the safety risks he posed to others, but the identifiable safety risk he seemed to pose to himself.

[90] Despite Mr. Gill's paranoid and disruptive yelling, the initial officers on the scene had no difficulty placing him at road side, handcuffing him and generally securing the scene. Indeed, resistance on the part of Mr. Gill did not occur until somewhat unexpectedly, while sitting handcuffed at road side, he violently arched his back and fell backwards. He remained on his back (handcuffed) at which point the ambulance pulled up beside him.

[91] It was at this point that Mr. Gill was becoming increasingly violent in his struggles. Because of his very large size and his powerful strength, the ambulance attendants required the assistance of five or six others to get him onto the stretcher. While attempting to put 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.

[92] Despite everyone's verbal attempts to reason with Mr. Gill and to generally calm him down, his aggressive struggling continued.

[93] On the evidence, it appears obvious that the police had no choice but to attempt to further restrain Mr. Gill. It is important to note that while excitable delirium was still not identified, it was clear by this time that everyone realized Mr. Gill needed to be calmed down for his own well-being. Accordingly, the police attempts at restraint required keeping Mr. Gill

on his stomach while various officers placed their feet gently on other parts of his body. This appeared to be the only measure of restraint that was working. As potentially harsh or severe as this restraint measure appears, the explanation offered by the officers clarifies that this is a technique learned in training and it is designed to impose little if any pressure. The idea is that pressure is not placed on the individual, but instead, the soft placement of the foot is intended to merely "give the sense of the officer's presence". No real pressure was placed on Mr. Gill's back or head. Nothing was done to block his airways or respiration.

[94] While the paramedics were attempting to treat the colleague that had been kicked by Mr. Gill, it became clear to one of the officers that in light of Mr. Gill's continuing and violent struggles, it would be necessary to shackle Mr. Gill's legs. As there were no shackles present in the patrol units, they had to be requested. The shackles were ordered "rush" and arrived a few minutes later. The evidence discloses that while awaiting the shackles, it was necessary to keep Mr. Gill on his stomach during which time he continued his erratic and violent struggling.

[95] In total, it would seem that Mr. Gill spent at least a few moments on his stomach after initially rolling off the gurney while awaiting the arrival of the shackles.

[96] Once the shackles arrived, they were applied to Mr. Gill's legs. He remained on his stomach as he was again placed on the stretcher. Up until

this point, no one noticed (the paramedics included) any problems or signs of distress in terms of Mr. Gill's breathing, wheezing, gasping or choking.

[97] In light of the disruptive and dangerous struggling on the part of this very big man, and because no one observed signs of distress (the paramedics included), no one at the scene expressed any concern about placing Mr. Gill on his stomach. Indeed, based on the evidence, the paramedics were in accord with the police that Mr. Gill needed to be restrained and that the manner of restraint employed seemed to be in the circumstances, the only measure that would be effective.

[98] After Mr. Gill had been placed on the stretcher in shackles and was being placed into the ambulance, one of the police officers noticed the first signs of obvious distress. The officer noticed that Mr. Gill no longer appeared to be breathing or was breathing inadequately. It was at that point that the paramedics asked the police to unshackle Mr. Gill and they began emergency treatment.

[99] In reviewing the evidence, it may be the case that the failure to diagnose or identify this as a case of excitable delirium, resulted in a manner of restraint (by placing Mr. Gill on his stomach) which was not ideal. In making that observation, I must at the same time acknowledge that even in those cases where excitable delirium is identified, the circumstances (relating to public safety) are often such that it may still be necessary to place an individual on his or her stomach (the Laura Lee

Draper case is a good example). Nonetheless, any such placement must obviously be minimized.

[100] This case involves a situation where although drug use seemed to be an obvious factor, the signs of excitable delirium seemed somewhat less clear. The increasingly erratic and violent behaviour of Mr. Gill seemed as consistent with general drug use or mental illness as with excitable delirium.

[101] Insofar as I have noted the failure to identify or diagnose excitable delirium, I must also note that irrespective of that failure, the size, strength and combativeness of Mr. Gill was such that the measures used to restrain Mr. Gill were not disproportionate. There were obvious concerns for everyone's safety.

[102] At one point in the evidence, one of the officers (Constable Bettans) who was present on the scene indicated: "Had we known that this was excitable delirium, we may have dealt with him somewhat differently." That being said, the failure to diagnose excitable delirium is as Dr. Palatnick observed, difficult indeed. In fact, it would be unfair in the extreme to evaluate too harshly the actions of the police and paramedics for doing certain things that "may not have been done" had they been able to make a diagnosis which the Court was earlier told, is often impossible to make.

3. The question of the sudden and rapid physical decline of the deceased.

Once having lapsed into distress, could the emergency responders have done anything different to save the deceased's life?

[103] The first signs of real distress occurred when Mr. Gill was being placed in the ambulance while on the stretcher. He had been placed face down on the stretcher (a continuation of his earlier position) and was by this time, leg shackled. The whole process of putting Mr. Gill back on the stretcher and transferring him into the ambulance, again took four people and approximately 40 seconds.

[104] At one point in the process of putting Mr. Gill into the ambulance, a police officer noticed that he no longer appeared to be breathing. The paramedics then confirmed the "agoninal respirations" and they asked the police to remove the handcuffs and the shackles and to turn Mr. Gill around onto his back.

[105] Now inside the ambulance with Mr. Gill, the paramedics proceeded to check for ceratoid pulse. One of the paramedics began preparing for resuscitative breathing while the other paramedic immediately called dispatch for a back up paramedic unit. A very short time later that back up unit arrived and according to paramedic Tazumi, they assisted with "full advanced life support measures".

[106] Despite the aggressive resuscitative measures initiated by the paramedics, Mr. Gill did not regain a pulse at the scene or on route the Health Sciences Centre.

[107] In reviewing all of the evidence, I can find that once distress was noted, the paramedics appeared to have responded with appropriate speed and attention. As in the tragic situation of Ms. Draper, Mr. Gill's condition regrettably entered into the "critical and fatal" stage of distress that so tragically accompanies excitable delirium. At that stage, it seems there was little that could be done. On the evidence that I received, there was nothing at this stage that the paramedics could have done that they did not do. Moreover, at no point in time in this final stage of distress was anything done by the police or the paramedics which could be viewed as inconsistent with the existing policy or general guidelines discussed by Dr. Palatnick.

VIII. CONCLUSIONS RESPECTING THE DEATH OF ARTHUR RANDY GILL

[108] It is clear that there was no formal identification or diagnosis of excitable delirium at the scene. With the Olympian detachment afforded to those who have the luxury of 20/20 hindsight, it is tempting to suggest that had such a diagnosis occurred, the restraining measures would have been different (avoidance of the prone position). While this fact was acknowledged by one of the police officers, it somewhat simplistically de-emphasizes three important points.

[109] First, it de-emphasizes what Dr. Palatnick and most others acknowledge is a very difficult state to diagnose, especially in the context in which it usually arises (fast moving situations where the initial contact with the individual in question gives rise to immediate safety concerns.)

[110] Second, it de-emphasizes what Dr. Palatnick candidly indicated was the impossibility in some situations of being able to use the “minimal’ and ideal sort of restraint recommended.

[111] Third, it de-emphasizes the tragic reality that accompanies most cases of excitable delirium. That is, even where all available emergency procedures have been taken and where all restraining measures are minimized and performed in an ideal fashion, the “bomb has already started to tick.” In other words, in most circumstances, sudden cardiac arrest becomes the norm not the exception.

IX. RECOMMENDATIONS ARISING FROM THE INQUESTS OF LAURA LEE DRAPER AND ARTHUR GILL

[112] Given the determinations I have made and given all that I have observed concerning the challenges and futilities associated with the emergency response to excitable delirium, it would be both immodest and intellectually dishonest to suggest that I have significant or original recommendations that could avoid similar deaths in the future. At best, my recommendations will serve as mere reminders of existing policy or policy currently in the development stage.

Recommendation No. 1:

[113] 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/or formal policies. All emergency services must remain vigilant to ensure that in this regard, their policies and training manuals are kept up to date and regularly monitored by employees.

Recommendation No. 2

[114] That the issue of police response and restraint in cases of excitable delirium be made a subject for future police training sessions relating to "use of force".

[115] I respectfully submit my recommendations and conclude this Report this 11th day of July 2005, at the City of Winnipeg, in Manitoba.

"Original signed by:"

Glenn D. Joyal, P.J.

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***

AND IN THE MATTER OF: **LAURA LEE DRAPER, DECEASED**
(DATE OF DEATH: FEBRUARY 23, 2002)

AND IN THE MATTER OF: **ARTHUR RANDY GILL, DECEASED**
(DATE OF DEATH: FEBRUARY 10, 2002)

EXHIBIT LIST

Exhibit No.	Description
1	WPS formal statement of Norman Cannon
2	WPS formal statement of Diane Cannon
3	WPS formal statement of Grant Nagam
4	WPS formal statement of Douglas Mann
5	Autopsy and medical examiner's report
6	St. Boniface Hospital Death Summary
7	Clinical Biochemistry regarding Draper
8	Explanation – Excited Delirium policy
9	Ambulance Care Report
10	Crime Lab Assistance Report
11	Curriculum vitae of Dr. Wesley Palatnick
12	Autopsy Report form
13	Clinical Biochemistry – St. Boniface

Exhibit No.	Description
14	Statement of Roy Harriott
15	Police complaint log
16	Statement of Leslie Tazumi
17	Statement of Wade McDonald
18	Statement of Grant Hansen
19	Statement of Adam Kosarych
20	Ambulance Patient Care Report
21	Police Call #024672
22	Crime Lab Assistance Report
23	Video tape surveillance
24	Video tape – role call video
25	Excited delirium document (47 pages)