ALBERTA

Report to the Minister of Justice and Solicitor General Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Law Courts

in the City (City, Town or Village) of Edmonton (Name of City, Town, Village), in the Province of Alberta,

on the 10th day of June, 2019 (year), (and by adjournment

on the 11th, 12th and 13th days of June, 2019 (year)),

before The Honourable Shelagh R. Creagh, a Provincial Court Judge,

into the death of Marcel Moisan (Name in Full) 49 (Age)

of 12004 – 58 Street, Edmonton (Residence) and the following findings were made:

Date and Time of Death: December 8, 2015 at 00:52

Place: Royal Alexandra Hospital, Edmonton

Medical Cause of Death:

("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – *Fatality Inquiries Act*, Section 1(d)).

Excited Delirium Syndrome as a consequence of Methamphetamine Toxicity

Manner of Death:

("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – *Fatality Inquiries Act*, Section 1(h)).

Accidental

In my report I will address four topics:

- Circumstances under which death occurred;
- Excited Delirium Syndrome;
- Police Response, and
- Recommendations.

1. Circumstances under which death occurred:

The Incident

Having heard the evidence of the witnesses called, and read all of the materials submitted in this case, I find that the circumstances under which death occurred are as follows:

Mr. Moisan (the deceased) used methamphetamine. On December 7, 2015 he used so much methamphetamine that his behaviour was out of control, frenzied and violent – so much so that both his teenage son, who was in the home at the time, and his neighbours, who lived in the other side of the duplex, feared for their safety. The neighbours called 911. Mr. Moisan also made a somewhat garbled call to 911, seeking the fire department.

Given these circumstances, police, ambulance and fire were sent to his home. The ambulance was kept a few blocks away while the police went into the home to see what was happening.

Once in the home, the officers found Mr. Moisan's son on the floor of the kitchen. The deceased was also in the kitchen. The deceased had a knife in his hand and was screaming nonsense. Broken glass was everywhere. An officer pulled the boy to safety; others tried to calm the deceased. He did not respond.

When words were unable to calm the deceased, force was used. In the end, the officers had to use both conducted energy weapons (CEW) and physical force to bring the deceased under physical control. Mr. Moisan ended up on the floor, on his stomach, handcuffed, hobbled and in a spit hood.

When the on-duty Watch Commander arrived, Mr. Moisan was restrained and still breathing. The Watch Commander directed the officers to remove the restraints and called the Emergency Medical Technicians (EMTs) in immediately. Shortly before EMS arrived, Mr. Moisan stopped breathing. The officers began CPR. The EMTs took over CPR once they were in the home. They were able to stabilize Mr. Moisan's condition to the extent that he could be transported to hospital. Regrettably, he died shortly after arrival at the hospital just after midnight.

I will make further reference to the evidence in the course of my report.

2. Excited Delirium Syndrome

In the opinion of Dr. Weinberg, the Medical Examiner who conducted the autopsy, Mr. Moisan died of "Excited Delirium Syndrome, due to Methamphetamine Toxicity." He added, "other Significant Conditions contributing to death but not causally related to immediate cause ... Struggle during police restraint." (See Autopsy Report, Tab 3, pages 3 and 4.)

In addition to Dr. Weinberg, Dr. Hall, a specialist in Emergency Medicine, who I accepted as an expert in the medical aspects of sudden in-custody deaths, including excited delirium and the medical effects of conductive energy weapons testified.[1]

Dr. Weinberg described Excited Delirium Syndrome as follows:

> I understand excited delirium to be a syndrome that occurs often as a result of stimulant drug use whereby the individual is displaying a certain spectrum of behavioural characteristics, and at least when I interact with these patients, there has been at the – generally, towards the conclusion of whatever incident is going on, when the individual has seemingly actually been gained under control, the individual goes into cardiorespiratory arrest. It basically means their heart stops effectively pumping blood and they're no longer breathing.
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> See Transcript, page 19, lines 1-7.

Dr. Weinberg also discussed the police reaction and the role of the restraints used by them in the death. He noted that:

- The use of conducted energy weapons did not account for the death;
- The blunt force injuries did not account for the death, and
- Neither causative nor traumatic asphyxia played a causative or contributory role in the death:
    - The spit mask was not completely deployed and did not occlude the breath;
    - The deceased was never in a position that precluded his ability to breathe; and
    - While he had injuries to his ribs they are consistent with CPR and medical intervention.

> Autopsy Report, Tab 3, page 5; Transcript, page 10, lines 27-30, page 17, lines 1-41 and page 16, lines11-40.

He concluded:

> It would ... I think it would be academically dishonest of me to not recognize that the struggles that was occurring did not at least play some role in creating that situation whereby the metabolic derangements were occurring and that is why the struggle is listed in part 2 as a contributory condition.
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> I don't believe it is the primary reason but, as I said I—I think it is academically honest and it is my best opinion that that struggle did contribute at least somewhat to the physiological derangements that were occurring in Mr. Moisan's body very shortly after midnight on December 8th that caused his heart to go into an arrythmia and stop effectively pumping blood to the rest of his body.

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[1] See Transcript, p. 4, l. 40 - p. 5, l. 1. *Viva Voce* evidence only: No written report was prepared by this Expert. In preparation for her testimony, the witness reviewed the following tabs in the Exhibit Binder: 3,4,5,7,8,12,23,31,32,38, including the following officer's statements: D'Avignon, Bateman, Hallonquist, Roy, Chipchase and Armstrong.

Transcript, page 21, line 39 to page 22, line 7.

I turn now to the evidence of Dr. Hall. She explained that while Excited Delirium is not accepted as a medical diagnosis[2], it is a condition that has frequently been observed in patients. She defined excited delirium as:

> ... Delirium[3] with psychomotor agitation, so the brain is busy and the body is busy and the excited terminology is meant to describe the underlying psychologic excitation that someone exhibits and is suffering from...So delirium simply described is an abnormal interaction with one's environment because two major elements aren't working. The first is perception, so that's input from our senses; sight, smell, taste touch sound. Those inputs come to people and they're erroneous and misperceived. And then there's the impaired cognition or thinking so the person can't reason their way through what they're experiencing.
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> When people are delirious they have impaired input from their senses, they often become paranoid, agitated, fearful, often violent but they can't reason their way through it... The excitation piece is about the underlying physiology and excited delirium was called that because we know that people who are in highly agitated delirious states have high heart rates, high blood pressures, often high temperatures, high respiratory rates and the psychologic demand is enormous for the system of someone who's got delirium with excitation.

She explained there were many causes for the condition:[4]

> ... – anything which makes the psychology go fast – the most common is stimulant, drug abuse, cocaine, methamphetamine, PCP, use of bath salts. (does not have to be high doses). Use of over-the-counter medications such as anticholinergic overdose. Other causes - psychosis, mental illness, schizophrenia, bipolar or manic crisis. Infected brain tissue, profound type O or low blood sugar, hypoglycemia.

She explained the physiologic aspects of drug induced Excited Delirium as follows:[5]

> ... something like cocaine or methamphetamine hijacks the dopamine system in the brain to make the body systems rev up and become very fast... once it is in the body, it must be processed because the drug itself poisons the reuptake system so the drug floods the brain and has to be used, there's no off button...over time [the drug] changed the mechanics of the brain such that fewer receptors are available to manage this large amount of drug, the drug stays in the system longer and the person begins to function at a level of high stimulation and psychologic excitation that we are not built for... when we exceed our body's ability to compensate, something very important in our body happens and that's the acidity in our blood can change...if we can't manage the body products of extreme activity for a period of time, then our pH drops... when that's challenged, the body tries to compensate, but if it can't ...then the normal enzyme functions in our bodies that keep us alive stop functioning and ultimately [he] will have a cardiac arrest.

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[2] Transcript, p. 9, l. 6; see also Transcript, p. 19, l. 29 - p. 20, l. 27.

[3] Transcript, p. 6, l. 17 - p. 7, l. 5.

[4] Transcript, p. 7, l. 12 - 32.

[5] The explanation for this is found over the course of the Transcript, pp 9-11.

She listed 10 behavioural characteristics of persons in the grip of Excited Delirium:[6]

(1) inappropriately clothed for environment,
(2) near constant activity,
(3) rapid movement,
(4) failure to tire,
(5) failure to respond to police presence,
(6) failure to respond to pain mediated control tactics,
(7) very strong,
(8) hot to the touch,
(9) breaking glass, and,
(10) rapid breathing.

She identified the following characteristics that were present in this case:

- breaking glass,
- constant activity,
- failing to respond to police presence, and
- failure to respond to painful attempt to control him (CEW).

Dr. Hall agreed with Dr. Weinberg: given the level of methamphetamine in Mr. Moisan's body, he was in the throes of Excited Delirium. Dr. Hall was asked if, in the course of her studies she had been able to draw any conclusions about the effect of the struggle during police restraint: specifically, might it contribute to death. Her response was:

> So the whys – I don't know this medical examiner – but he's articulated that that's part of the picture. But, not, you know, not causal. It's not that struggle equals death. So it's – I think it's just responsible reporting, it's – we see – we see this – struggle always happens, it's just the nature of the person that's being restrained. It's not that the struggle caused the death per se.[7]

In her opinion, based on the level of methamphetamine Mr. Moisan ingested and the description of his behaviour, it was necessary for police to gain physical control of Mr. Moisan so he could be treated medically.[8]

She was also asked whether there is a link between the use of CEW and death in Excited Delirium cases. In her view:

> … the effects of a CEW in a cumulative way would be insignificant in anyone with excited delirium. It is an appropriate way of gaining control in individuals with Excited Delirium it will not make it worse.[9]

Finally, she commented on the impact on the work done by the EMT and the death of Mr. Moisan:

> It is a well-documented resuscitation and a very appropriate chain of resuscitation was undertaken. They recognized the rhythms that Mr. Moisan was exhibiting and took appropriate steps to try to correct them. They actually got a return of circulation early on that did not last long. They thought they had a pulse

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[6] Transcript, p. 8, l. 4 - p. 9, l. 2. Six or more of these features is probably a case of Excited Delirium. The higher the number of features, the worse it is.

[7] Transcript, p. 17, l. 12-17.

[8] Transcript, p.14, line 22 – p. 15, l. 15.

[9] Transcript, p. 23, l. 38 - p. 24, l. 11.

> and then lost that pulse which happens a lot in pre-hospital resuscitation. The drugs and the doses are appropriate to the situation.[10]

3. Police Response

With those comments in mind, I turn to the police and EMT response in this situation.

From my review of the evidence, I conclude that when the police officers entered the Moisan residence, they were confronted by an extremely agitated man, armed with a knife, who did not respond or seem to understand, their comments. There was also a boy huddled on the floor. They were also aware that there were neighbours on the other side of the duplex who were afraid of what was going on.

Once on scene, some of the officers involved had in mind the possibility that the deceased was in a state of Excited Delirium. In addition, the Watch Commander had experience in the area and relied on that experience in this situation when he directed the restraints be removed and CPR begin.

The following Edmonton Police Service policies and procedures were presented and discussed:

- Reasonable Officer Response Procedure,
- Use of Force Policy,
- Use of Force Equipment Procedure, and
- Use of Conducted Energy Procedure.

There was also documents relating to:

- Professionalism in Policing;
- Reasonable Officer Response documents, and
- a presentation on Recruit Training and videos on Excited Delirium.

These policies and procedures were followed by the officers on scene. Their choice of non-lethal weapons – the CEWs – was entirely appropriate. The fact that this might be a case of Excited Delirium was in the minds of the officers and their actions complied with the Edmonton Police Service policies and procedures in effect at that time.

Dr. Hall has already commented on the work done by the EMT's and considered it appropriate (see above).

Given the evidence in this Inquiry, I conclude that the police officers followed their policies and procedures and that their training was adequate to the state of knowledge with respect to Excited Delirium Syndrome that exists at this time.

4. Recommendations for the prevention of similar deaths:

I have been able to locate five other Fatality Inquiry Reports that dealt with death during Excited Delirium and police action in Alberta over the last eight years:

May 18, 2012 – Report re the death of **Trevor Grimolfson**
Drug involved: Ecstasy (MMDA) and Ketamine
No recommendations

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[10] Transcript, p. 24, l. 24-30.

August 24, 2014 – Report re the death of **Grant William Prentice**
Drug involved: Cocaine
September 30, 2016 – Report re the death of **Simon Chung**
Drug involved: Methamphetamine
June 7, 2017 – Report re the death of **Marc Andre Fontaine**
Drug involved: Cocaine
March 8, 2018 – Report re the death of **Jeffrey Tyler Oatway**
Drug involved: Cocaine

The recommendations made by my colleagues in these reports fall within the following categories: (Since Fontaine and Prentice deal with RCMP incidents, I have generalized the recommendations and not set out those that deal with specialized rural systems.)

1. **Training of officers, operators and dispatchers.**
   - All officers who will interact with the public must be trained to recognize person exhibiting Excited Delirium syndrome symptoms.
     - The policies and training should deal with Excited Delirium on its own, not always tied to use of force issues. (Chung)
   - Training generally (Fontaine) and continual refreshers, given how the state of knowledge on the Syndrome is growing (Prentice).
   - Training for officers in use of CEW. (Prentice)
   - Training for operators and dispatchers so the syndrome or the prospect of it can be identified as early in the incident as possible. (Fontaine)

2. **Early call for medical assistance.**
   - Improving the delivery of EMS services to subjects presenting with the syndrome with recommendations to improve communication with 911 system. (Fontaine)
   - Officers to call for medical assistance as soon as the syndrome is suspected. (Chung)

3. **Develop a consistent and common terminology to use in this situation so communication and coding between RCMP, emergency personnel and medical staff is simplified.**

While the report in the death of Mr. Oatway was not in existence when this incident occurred, I have concluded that my colleague's recommendations were generally considered as the Edmonton Police Service has recently reviewed their policies and procedures documents to ensure they were up to date.

My recommendations are:

1. That the Edmonton Police Service continue to keep its members up to date on the knowledge of Excited Delirium by regularly conducting training sessions or briefings on this topic.

2. Ensure that their policies on Excited Delirium Syndrome are up-to-date and consistent with the available knowledge on the topic.

3. To continue with the training and use of non-lethal weapons such as the CEW.

4. I join my colleague Judge Lepp in his observation that Excited Delirium is still poorly understood, and I also join him in recommending that the police forces in Alberta continue to "marshal and communicate any data collected by them" to Dr. Hall or any other

researcher that has been identified by them. Knowledge is the best weapon to guide reaction in these circumstances and all possible steps should be taken to develop it.

Conclusion

Mr. Moisan's death was undoubtedly a tragedy to his family. It is clear from my review of the reports listed above that these are difficult cases and serve as examples of the toll that drug use/addiction takes on our society. To paraphrase my colleague, Judge Lepp, Mr. Moisan is a victim of methamphetamine.

Excited Delirium poses a conundrum for police officers who encounter it. The Delirium is a medical issue and requires medical treatment. However, the person in the grip of the Delirium is usually on a violent rampage, endangering themselves, bystanders and the police officers. The person cannot be treated medically until they are calm or at least under control. Sadly, calm and control is rarely available by means other than violent confrontation.

Whether or not the actions of the police bringing the person under control aggravate the underlying problem cannot be answered given the current state of knowledge of the Delirium. In the meantime, confrontation and use of force remain the only tools available to ensure the calm and control that enables the necessary medical intervention. Regrettably, this situation is likely to re-occur until better tools are found and this conundrum is eliminated.

DATED January 8, 2021

at Edmonton, Alberta.

Original Signed

Shelagh R. Creagh
A Judge of the Provincial Court of Alberta