ALBERTA

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the The Law Courts

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

on the 5th day of September, 2017 (year), (and by adjournment

on the 6th, 7th and 8th days of September, 2017 (year)),

Before Greg Lepp, a Provincial Court Judge,

into the death of Jeffrey Tyler Oatway (Name in Full) 34 (Age)

of Stony Plain, Alberta (Residence) and the following findings were made:

Date and Time of Death: April 13, 2012 at 14:40 hours

Place: Royal Alexandra Hospital, Edmonton, Alberta

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 with methamphetamine use[i]

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)).

Unclassifiable

A. Circumstances under which Death occurred:

1. Before the Arrest of Mr. Oatway:

Jeffrey Oatway was an engaging man, well-loved by his family. His death is a heartbreaking tragedy. His life prior to his arrest on April 11, 2012 was difficult. He was suffering from anxiety and paranoia and used methamphetamine and other illegal drugs regularly. In the weeks leading up to his arrest on April 11, 2012 he was homeless and spending time in a number of shelters in downtown Edmonton. His parents, Clifton (Clif) and Simone Oatway, lived on an acreage near Stony Plain, just West of Edmonton. They did their best to assist their son in getting medical help but this quest proved to be frustrating.

From time to time, Jeffery Oatway would make his way to his parents' house by taking the bus and hitchhiking. He would come to ask for some money, to wash his clothes and to shower and rest. Sometimes he had not slept or showered for a considerable time. He was often anxious and needed a break from his stressful homeless situation. He made one of these trips on April 10, 2012. Despite difficulties Jeffrey had caused before at home, Clif Oatway was prepared to help his son but he made it clear that his (Clif's) vehicle was off limits. Despite this, Jeffrey took his father's car and twenty dollars and left his parents' home at about 9:00 PM on April 10.

2. Arrest of Mr. Oatway:

On April 11, 2012, just before 8:00 AM, Cst. Chris McFarlane of the Edmonton Police Service ("EPS") was on patrol on Whitemud Drive near 159 Street and came across a collision unrelated to Mr. Oatway in the middle of three Westbound lanes of busy rush hour traffic. He stopped and put the emergency lights of his police vehicle on to warn oncoming traffic of the collision. A civilian then reported to him that a man was walking in the Eastbound lanes of traffic across the median from Cst. McFarlane's location and was attempting to enter a vehicle. The civilian also noticed that the man had a plastic bag hanging out of his back pocket. That man was Jeffrey Oatway.

Cst. McFarlane yelled at Mr. Oatway to come to the police vehicle in order to get him out of traffic. Mr. Oatway complied and, while walking to the police vehicle, threw something away. Mr. Oatway followed Cst. McFarlane's direction to take a seat in the back of the police vehicle, following which Cst. McFarlane did a quick search and found some cigarettes and a vehicle key on Mr. Oatway's person. Mr. Oatway denied having a plastic bag when asked.

Mr. Oatway properly identified himself and told Cst McFarlane that he had earlier flipped his own vehicle on the Eastbound Whitemud. Cst. McFarlane confirmed his identity on the police computer and also discovered that Mr. Oatway was criminally prohibited from driving. He brought Mr. Oatway out of the police vehicle and put him under arrest for this offense and handcuffed him.

All the while, Mr. Oatway was cooperative and understood what was being said to him. Cst. McFarlane did, however, think that he might be high on something. He suspected that the item Mr. Oatway threw away on the road was a methamphetamine or crack cocaine pipe.

Mr. Oatway told the police that he had taken his father's vehicle in Stony Plain without consent, driven to a friend's place and was then run off the road on the Whitemud. He said that he needed his cell phone and his glasses which were still in his father's vehicle. Cst McFarlane retrieved these items while another police member kept an eye on Mr. Oatway. While retrieving Mr. Oatway's items, Cst. McFarlane noticed a pile of smashed glass on the road which he presumed was the drug pipe Mr. Oatway discarded after it had been run over by many vehicles on the busy Whitemud.

While driving Mr. Oatway to the Southwest Division police station, Cst. McFarlane asked him if he had taken any drugs and if he wanted medical attention because of the collision he experienced. Mr. Oatway declined medical attention and told Cst. McFarlane he did not do drugs. Cst. McFarlane received word that Mr. Oatway's father had lodged a complaint with the Stony Plain RCMPolice about Mr. Oatway's taking his vehicle. In the end the EPS charged Mr. Oatway with disqualified driving and taking a motor vehicle without the consent of the owner.

3. At Southwest Division:

When Mr. Oatway arrived at Southwest Division at 9:01 AM, the Staff Sergeant in charge decided to have Emergency Medical Services ("EMS") attend because Mr. Oatway was involved in a collision even though Mr. Oatway indicated he did not need medical help. Within ten minutes EMS arrived and asked Mr. Oatway some questions before being satisfied there was nothing to be concerned about.

Noticing that Mr. Oatway's pupils were very large in the bright police station, Cst. McFarlane once again asked about drugs. Mr. Oatway finally admitted doing two or three "points" of meth about two days ago and drinking six beer recently. This was not enough to cause Cst. McFarlane to be concerned.

The EPS decided not to release Mr. Oatway on bail directly from the Southwest Division. Rather, his legal situation was serious enough to warrant his making an appearance before a Justice of the Peace in downtown Edmonton to speak to his judicial interim release. This meant that he would be transported and held at EPS Headquarters in the Arrest Processing Unit ("APU") until his bail hearing.

While Mr. Oatway was waiting to be transported, Cst. McFarlane noticed that he appeared a little anxious. He did not take a seat in his cell but remained standing and was continually picking and biting at his nails and fingers. He asked for some toilet paper but did nothing with it when it was provided.

Mr. Oatway left Southwest Division with Cst. McFarlane at 1:02 PM. He was polite and quiet during the trip downtown. The only exchange Cst. McFarlane recalled was a request by Mr. Oatway to have the handcuffs loosened which request was facilitated.

4. Arrival at the Arrest Processing Unit:

APU, now referred to as the Detention Management Unit ("DMU"), is located in the lower level of EPS headquarters. At the time it was staffed by a Sergeant and four Community Peace Officers commonly referred to as Commissionaires.

Vehicles arriving at APU entered a large sally port which led by a passage door into a foyer dominated by a reception counter. Behind the counter was an area referred to as "the pod" containing a number of work stations for staff and a large number of computers and monitors. Flat screen monitors on the wall showed all areas of the APU so that prisoners' activities could be monitored centrally. All controls for the opening and closing of doors were also located in the pod.

Originally, in order to keep the pod secure, there was a floor-to-ceiling bullet resistant Plexiglass divider extending from the counter to the ceiling. Since the pod was a confined space with a large collection of electronics, staff found it to be too hot. The floor-to-ceiling Plexiglass divider was removed and a Plexiglas divider extending only about two feet above the reception counter was installed instead. The area from the end of the divider to the ceiling was open to allow better

ventilation. Following the incident leading to Mr. Oatway's death wire mesh was installed extending from the top of the clear two foot divider to the ceiling.

From the reception foyer there were two hallways leading to the cells. The doors to these hallways were left open so that staff in the pod could hear if there was a problem in the cell area.

Sgt. Dave Beattie was in charge of APU when Mr. Oatway arrived at 1:23 PM. APU staff searched Mr. Oatway again which was standard procedure on admission. He was again asked about drug consumption and told APU what he had earlier told Cst. McFarlane. He added that he was also on some prescription medication, Clonazepam and Zopiclone to control his anxiety.

Mr. Oatway's handcuffs were removed and, at 2:58 PM, he was fingerprinted, photographed and given an opportunity to use the telephone. During this time no concerns were noted about Mr. Oatway's behaviour.

Following this, he was taken back to his cell to await his bail hearing before a Justice of the Peace. While waiting, staff monitoring the video noticed that he appeared to be pacing back and forth and had removed some of his clothing.

5. The Struggle:

A compilation of relevant video from the APU was introduced in evidence at the Inquiry. It was very helpful in piecing together what occurred during the violent struggle I will describe below. Witnesses employed by EPS and EMS testified at the Inquiry. Detainees were also present at APU, witnessed some of the events, and gave statements to the police. Only one of the detainees could be located when witnesses were being marshalled for this Inquiry. He was unwilling to testify. The materials prepared by Inquiry Counsel contain copies of the statements made by the detainees and I have read them. The accounts given by the various witnesses differ to some degree, which is understandable given the circumstances, but, particularly because of the video, it is not difficult for me to find make findings of fact.

Mr. Oatway's turn to see the Justice of the Peace came at about 3:52 PM. Community Peace Officer ("CPO") Bryan MacKenzie went to Mr. Oatway's cell to fetch him. As he did in every such case, CPO MacKenzie opened the cell door and asked Mr. Oatway to turn around so that he could be handcuffed. Mr. Oatway, who was, by this time, clothed in a t-shirt and long underwear, loudly refused. CPO MacKenzie locked the door to his cell and called for assistance. CPO Darren Fiedler came from the pod and the cell was, once again, unlocked. Mr. Oatway almost immediately pushed past the two men and ran down the hall through the foyer and into the sally port with the two CPOs in pursuit. They were immediately joined by Cst. Jennifer Sandmeier and Cst. Paasuke.

The doors leading to the outside from the sally port were locked so there was nowhere for Mr. Oatway to go. He removed the receiver from a wall telephone in the sally port but this was immediately retrieved by Cst. Sandmeier. The four officers attempted to corral Mr. Oatway but he was too elusive. He circled and weaved through the sally port for about thirty seconds in total with the four officers in pursuit. At one point the two burly male CPOs grabbed his arms but he shook them off easily. Also during this brief pursuit in the sally port. Mr. Oatway took a swing at Cst. Paasuke but did not hit her.

I note at this point that Mr. Oatway was just under 6 feet in height and probably weighed just over 200 pounds. A precise weight at the time of the autopsy could not be taken because the scale was out of order.

After the brief chase in the sally port, Mr. Oatway ran back into the foyer and, in one jaw-dropping

motion, dove head first over the Plexiglas barrier at the front counter and into the pod. The pod had many desks and work stations equipped with normal office kits like pens, scissors, staplers, computers and monitors.

There is no video of what transpired in the pod area. Cameras recorded all events at the APU except the pod, because it was an area off limits to inmates. The four officers who were chasing Mr. Oatway around in the sally port entered a passage door into the pod to attempt to subdue him. In the process of so doing, the passage door from the foyer to the cell area was closed. This was a wise decision since the pod area contains switches from which cell doors can be opened remotely. If Mr. Oatway were to have opened any cell doors from the pod the freed detainees would still have been contained in the hallway.

There is no video depicting how Mr. Oatway landed in the pod area. It would, no doubt, have been painful landing head first from a height of about five feet into a collection of workstations and equipment. Once in the pod, Mr. Oatway stood on a desk with his back to the wall and started attempting to throw flat screen monitors and everything else he could lay his hands on at the officers. Thankfully, the monitors were affixed to the wall with cables so nobody was hit. The officers stood back until all potential projectiles were thrown. Cst. Sandmeier hit a panic button in the pod which alerted members on the floor above the APU that there was an emergency. When an inquiring phone call was received, she reported that help was needed urgently. At least 13 other officers from elsewhere in headquarters streamed into the pod to assist with Mr. Oatway while at least a dozen more collected in the foyer area outside of the pod in response to the call for assistance.

It was extremely dangerous for Mr. Oatway to be in the pod. Not only did the pod contain a number of large number of items that could be used as weapons but there was also a serious risk he would activate one or more of the remote locks and free detainees. It was not the place for any detainee let alone one demonstrating erratic and assaultive behaviour.

Mr. Oatway was in the pod for about five minutes in total. During that time he vigorously resisted all attempts by the officers to subdue him and he did not respond at all to verbal commands. He was sweating and red and was making grunting noises like an animal. The attending members recall him having what they referred to as super human strength. The members wrestled Mr. Oatway and struck him with closed fists and knees with the end goal of restraining him with his hands handcuffed behind his back. These pain techniques appeared to have no effect on him. Mr. Oatway was pulled off his feet down onto the desk upon which he was initially standing and then wrestled to the floor before his hands were handcuffed in front of him and a hobble affixed to his legs.

The members knew that handcuffing in front rather than behind was a less than optimal measure. A person cuffed in front can still administer blows and there is a risk as well that the cuff chain can be looped over another person's head and used as a garrote. As well, a hobble is a very effective restraint technique if it is affixed to handcuffs behind the back but it is of more limited use if the handcuffs are in front. This method of fettering was the best the police could do with an extremely combative Mr. Oatway.

One of the members who entered the pod was Cst. Nicole Akers, a qualified Conductive Energy Weapon ("CEW") operator and she had a CEW on her belt. The CEW is often referred to colloquially as a "Taser" after its manufacturer. When Cst. Akers entered the pod the other members were still struggling mightily with Mr. Oatway and the area was strewn with monitors, broken glass and other detritus. The air was hazy with smoke from the damaged electronics and dust from items being disturbed. Many of the members were coughing and exhausted from their struggle with Mr. Oatway.

From her training and her observations of Mr. Oatway, Cst Akers concluded that he was likely experiencing Excited Delirium Syndrome ("ExDS"). She concluded that it would be appropriate to use the CEW to try and gain control of Mr. Oatway. Her training taught her that it was an intermediate use modality that could be used on an active resister when other attempts at restraint were not effective. That situation was present in the pod when she entered and she told the other members that it should be used. Because of the struggle and the proximity of other members, she could not get in a position to deploy the CEW effectively in the pod.

The members eventually carried Mr. Oatway out of the pod to a more controlled environment being dry cell 125, which was right across the hall. A cell is "dry" when it is devoid of plumbing fixtures. Unlike the pod, cell 125 had an operating video camera but, unfortunately, during much of the time the police were dealing with Mr. Oatway, one of the members was standing immediately in front of the ceiling-mounted camera. The members hoped to get Mr. Oatway handcuffed behind his back and have the handcuffs attached to a fixed bench in 125.

Eight members and Mr. Oatway were crowded into tiny dry cell 125. Mr. Oatway, despite being hobbled and handcuffed in front was still struggling violently. He was also curling up and trying to move under the bench in the small room. During the struggle he bit the gloved finger of Cst. Scott Carter who called out. At this point, Cst. Akers entered the room and told Mr. Oatway to stop biting or she would deploy the taser. She also asked other members to call Emergency Medical Services ("EMS"). EMS is always called when a CEW is used to assess the recipient of the weapon and to remove darts if they are deployed. Mr. Oatway did not stop biting so she yelled "taser taser" to alert the other members and deployed the CEW in probe mode where darts are ejected from the weapon, penetrate and stick in the flesh of the subject to administer electric current.

Cst. Akers' CEW was deployed between 4:00.09 and 4:00.49 PM. The exact time of deployment could not be determined because the camera was being obstructed and the CEW's internal clock was not aligned with the clock on the camera in cell 125. The CEW was deployed twice, once for five seconds and a second time for six. It did not appear to have much of an effect on Mr. Oatway. Members recall that he was still struggling after its application and was complaining that there was a knee on his chest. This is supported by the video which shows members still struggling with Mr. Oatway after the wires of the deployed CEW are visible.

Mr. Oatway was in cell 125 for a total of 2 minutes and twenty seconds and was removed at 4:02.04 PM. His struggling slowed and the police then carried him to the foyer, turned him on his stomach and handcuffed him behind his back. He was then put in the "recovery position" on his side. Moments after he was put in this position, the police noticed that he had stopped breathing. Significantly, he was still moving around more than a minute after the latest time the CEW could have been deployed.

Immediately, an Automated External Defibrillator ("AED") from the APU was prepared and Mr. Oatway was put on his back in preparation for its application. Mr. Oatway started breathing again so the AED was not applied. At some point during this series of events in the foyer, Cst. Akers took his pulse and found that he had one although she noticed that he was turning blue. He was once again returned to the recovery position. After a few minutes the police carried him to the sally port area. It was less crowded and cooler there.

Seconds after Mr. Oatway was placed on the floor of the sally port the police noticed that he had once again stopped breathing. He was put on his back and the AED was put on his chest. This device reads the electrical activity of the heart and either defibrillates automatically, if appropriate, or displays a readout indicating chest compressions should begin if there is no shockable rhythm. In this case, it did the latter and the members appropriately began Cardio-Pulmonary Resuscitation ("CPR").

Michael Henning, An Emergency Medical Technician ("EMT") at the time, arrived at 4:14 PM, after receiving a dispatch at 4:08 PM. The ambulance he was in arrived seconds after the EPS started CPR. Mr. Henning's dispatch was one of high priority rating either "delta" or "echo" on the scale used at the time by EMS, meaning it was life threatening.

After EMS arrived, Mr. Oatway was put on the gurney immediately and transported to the Royal Alexandra Hospital a short distance away. On the way he was intubated and an intravenous line was inserted. Mr. Oatway was administered Epinephrine and Atropine since he was in asystole. He arrived at the hospital at 4:38 PM.

Mr. Henning was very familiar with ExDS. He testified that when a patient is showing signs of this Syndrome the priority for EMS is to administer drugs like Midazolam intravenously or intramuscularly to calm the patient down. If the patient is combative, EMTs can do this only when the situation is controlled by the police and it is safe. On the other hand, police, who are tasked with creating a safe situation, are not well placed to administer drugs like Midazolam. It is possible for a patient being administered this mediation to stop breathing so it is essential that it be administered only by someone, like an EMT, who is trained in intubation.

In Mr. Oatway's case, of course, sedation was not necessary. Where an ExDS patient is in cardiac arrest, Mr. Henning was aware that administration of sodium bicarbonate at a stage earlier than would be the case in a non-ExDS patient in arrest might be indicated. Here, however, they were so close to the hospital that its administration would not have made a difference.

Mr. Oatway's heart did begin beating again but he never regained consciousness and was brain dead. On April 13, 2012 a decision was made to disconnect him from life support.

6. Post Mortem:

Dr. Graeme Dowling, formerly the Chief Medical Examiner for Alberta, and a medical examiner at the time, performed the autopsy on Mr. Oatway on April 16, 2012. He noted changes to the body consistent with his hospital treatment and also noted a great many scrapes and bruises and CEW probe marks that resulted from the prolonged struggle Mr. Oatway had with the police. He concluded that Mr. Oatway died from Excited Delirium Syndrome with presumed methamphetamine use. None of the injuries caused his death and there were no natural disease processes apparent that would have caused his death.

He opined specifically that the CEW did not electrocute Mr. Oatway. If the CEW stopped his heart Mr. Oatway would have been unresponsive seconds after deployment. The video shows that he was struggling for an additional two to five minutes. Additionally, the location of the CEW probes essentially ruled out any possibility of electrical capture of the heart which would have increased the risk of electrocution. Although Dr. Dowling offered that you can never say that the CEW had nothing to do with death after deployment, the same could also be said for the other traumas that Mr. Oatway was experiencing prior to his loss of consciousness. In other words, from a medical perspective, the CEW administration certainly did Mr. Oatway no good. Neither did being punched and kneed and wrestled with by the EPS members.

Mr. Oatway did not have detectable levels of methamphetamine in his blood. Dr. Craig Chatterton, the Deputy Chief Toxicologist at the Office of the Chief Medical Examiner, gave evidence that the half-life of methamphetamine in the body is unpredictable and depends on the PH of the body. Generally it ranges from 12 to 24 hours after consumption.

Although there was no methamphetamine detected in Mr. Oatway's blood, it was detected in his

urine. Substances in the urine were obviously present in the blood previously. The toxicological evidence is, therefore, consistent with what Mr. Oatway reported to the police about consuming methamphetamine about two days prior to the incident on the Whitemud. Dr. Chatterton also found trace amounts of prescription anti-anxiety medications in Mr. Oatway's blood consistent with his treatment for this illness. The levels of this medication were inconsequential.

B. Purpose of Inquiry and Discipline in the Analysis:

As with any public fatality inquiry, my task in this one is to determine the cause and manner of death and to make recommendations to prevent future deaths in like circumstances, if possible. These Inquiries are held in public and the reports published for the purpose of subjecting the behaviour of the actors involved and my findings to public scrutiny.

Public Fatality Inquiries are presided over by a judge because judges are experienced in assessing evidence dispassionately and fairly. Key issues arose in this Inquiry beyond my knowledge and experience as a lay person. As a result, expert witnesses were called to testify about ExDS and the use of CEWs. I had the benefit of the evidence of Dr. Christine Hall, an expert in ExDS, and Inspector Chris Butler of the Calgary Police Service (CPS) who is an expert in police use of force. Inquiry Counsel also provided me with scholarly articles dealing with both ExDS and use of the CEW. The expert evidence on these two issues forms the foundation for my task at this Inquiry. Although the experts obviously know far more that I do about ExDS and the use of CEWs, I am not obliged to accept their evidence without question. If I did so I would be shirking my responsibility. In assessing their evidence and determining how it applies to the facts I found in this Inquiry, I must be careful, however. At times, their opinions appear very counter-intuitive to a lay person. It would be a grave error to attempt to use "common sense" in assessing the expert evidence and applying it to the facts I found. Instead, I must insure that I carefully scrutinize the expert evidence only using logic and science.

I will first set out the evidence I accept regarding ExDS and CEWs. Using the foundation of that evidence I will answer a number of questions that a member of the public might ask when scrutinizing this report. The answers to those questions form the basis for the recommendations I make.

C. Excited Delirium Syndrome:

1. Characteristics of ExDS:

There is significant debate as to whether ExDS is a definable medical condition. The American Civil Liberties Union suggested in 2007 that ExDS was made up to whitewash police use of force.[ii] There are other publications making similar claims. ExDS is not found in the DSM-5[iii] but is accepted by the National Association of Medical Examiners and the American College of Emergency Physicians, according to Dr. Hall.

Some of this controversy exists because ExDS is still poorly understood even by experts who believe that it is a definable medical condition. One of the reasons for this is poor sample size (it is rare) and the fact that is does not arise in a clinical setting like a hospital or a lab where it can be studied more effectively. Another reason for the controversy is that even those who conclude it is a definable medical condition cannot say exactly how death is caused. There is never an identifiable cause of death at autopsy. Even in 2018 there is a great deal in medical science that is simply not known.

What is more perplexing is that ExDS often occurs in men[iv] like Mr. Oatway, who are under the age of forty. It is very rare that young men with no significant medical conditions apparent at autopsy die and cannot be resuscitated.

Although ExDS is poorly understood, what can be said is that there is in medical literature strong evidence that a significant number of young men die after showing remarkably similar, and very unusual, clinical features. Common to all is acute delirium (disturbance in cognition and perception) and agitation. Those who have experienced ExDS often use cocaine, methamphetamine or MDMA, or other drugs and may also be suffering from mental illness. "Common sense" would lead one to believe that a high recent dose of drugs will trigger an ExDS event. But chronic use is also significant as will be described below.

The remarkably similar ten characteristics of a person experiencing ExDS are:

- Partial or complete disrobing
- No response to police presence
- Constant or near constant physical activity
- Imperviousness to pain
- Tendency not to fatigue
- Out of proportion strength
- Rapid breathing
- Hyperthermia
- Profuse sweating
- The making of animalistic sounds
- Attraction to glass or shiny objects.

2. Causes of ExDS:

There is strong support for the theory that ExDS is caused by dysregulation of the dopamine transporter function. Dopamine is a neurotransmitter. In normal individuals, it is present at nerve synapses in a regulated amount. Mechanisms exist in a healthy person to transport excess dopamine from the synapses. These mechanisms prevent dopamine from accumulating at the synapses in amounts that would affect normal neural function.

Cocaine, methamphetamine and some other drugs act to inhibit the normal reuptake of dopamine with the result that the user has elevated dopamine levels in the synapses. This results in the sought after "high" for users of those drugs. The bodies of chronic users of cocaine and methamphetamine often adapt to the chronic presence of higher than normal levels of dopamine by developing an increased capacity to transport dopamine out of the synapse. Chronic users, when not using, therefore often have lower than normal levels of dopamine in the synapse resulting from this abnormally increased transport function. This leads to an increased desire for the drug.

In some chronic cocaine and methamphetamine users, for reasons unknown, the process of dopamine reuptake becomes completely dysregulated and the synapses are flooded with dopamine, a situation known as hyperdopaminergia, and there is little ability for reuptake. Because dopamine is a neurotransmitter, neurons throughout the body fire uncontrollably. The result can be ExDS which, again, is acute delirium and extreme excitation or agitation. Because there is a limited capacity for the reuptake of dopamine for these sufferers, ExDS is like a runaway train. At the risk of mixing metaphors, I analogize it to an internal combustion engine with no governor and the throttle wide open. Eventually, just like a well-functioning engine fails in those circumstances, even a healthy young body will be overtaxed and death will likely result when ExDS is experienced.

3. Preventing Death from ExDS:

Even though death is very often the result of ExDS, it is not inevitable. There are cases where patients survive. Given the poorly understood nature of the Syndrome, currently it is unknown when the Rubicon is crossed and collapse and death are inevitable.

To stop the runaway train, heavy sedation is required as soon as possible. It is the only hope of survival but is not a guarantee. Once the patient is sedated and transported to hospital, treatment involves addressing hyperthermia, attendant dehydration and the other metabolic processes that are leading to the patient's demise.

Before sedation can occur, the patient must be controlled urgently. Here is where most of the controversy arises in these cases. Frequently, because of the bizarre and dangerous behaviour exhibited by subjects suffering from ExDS, the police are involved and take steps to effect control. In many cases, because of the difficulty in establishing control of subjects exhibiting the characteristics set out above, CEWs are deployed. The subject often becomes unresponsive shortly thereafter and "common sense" leads people to believe that the CEW killed the subject.

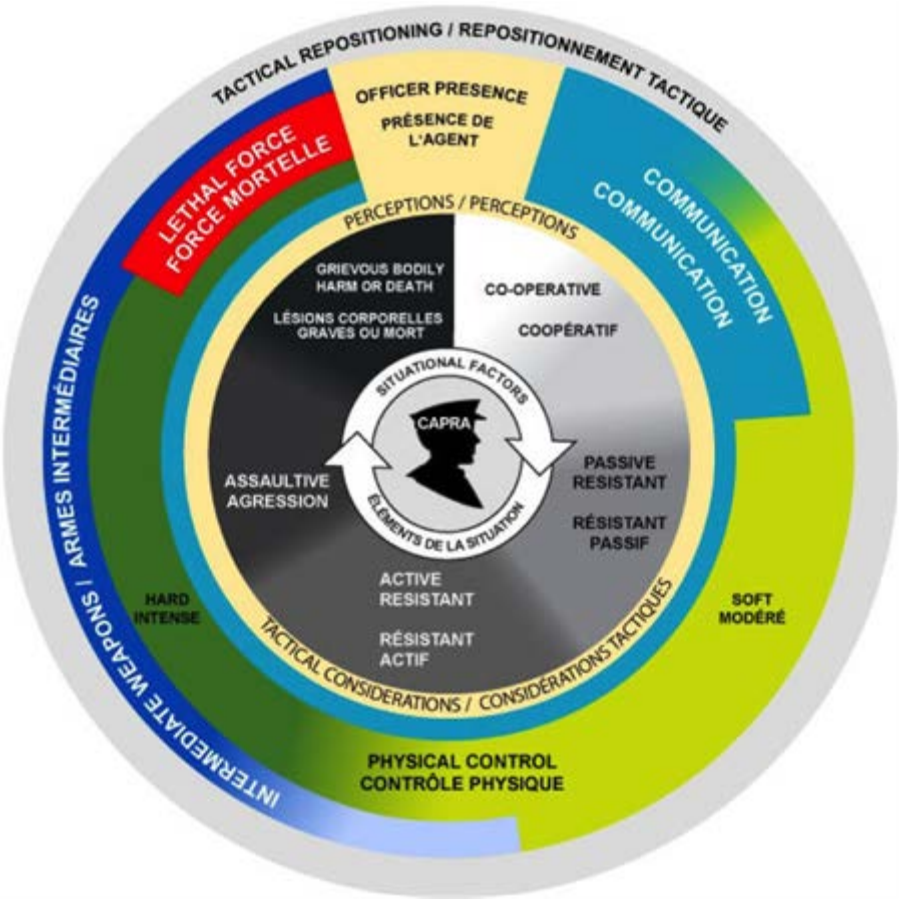
Conducted Energy Weapons:

1. Characteristics:

CEWs are intermediate weapons in the police arsenal. Their use in the law enforcement community is very widespread. When used in "probe mode" as they were with Mr. Oatway, the CEW uses compressed nitrogen to eject two barbed metal probes, connected to the weapon by thin wires. The probes enter the flesh of the subject and complete a circuit so that electricity from the device flows through the body of the subject between the two probes. The weapon is designed to incapacitate the subject temporarily by paralyzing the muscles. During the time the weapon is cycling the police have a five second or so window of opportunity to handcuff and subdue the subject.

2. Reasonable Officer Response Model:

The Reasonable Officer Response (ROR) model used in police training and forming the basis of the EPS use of force policy requires any force used against a subject to be proportionate to the level of resistance, threat or violence displayed by the subject. Under the ROR model, as the behaviour of the subject becomes more threatening, aggressive and violent, the appropriate level of force increases. The level of force to be used also depends on environmental and other factors. The ROR model is graphically illustrated below.



The CEW is an intermediate weapon and, according to the ROR model, its use is generally proportionate where the subject is actively resisting or assaultive and less extreme use of force techniques would be or are ineffective.

3. Risk of Bodily Harm or Death:

Although there is a significant controversy regarding the use of CEWs, studies have shown consistently that, although there is a risk of bodily harm and death, that risk is exceeding small. In a published study conducted by the CPS, referred to by Inspector Butler in his evidence, during the study period, only .07% of all police interactions with members of the public involved police use of force. Of the 562 total use of force incidents, 271 involved the use of a CEW. Of those, only 13% resulted in injury to the subject requiring treatment, far less than the 18% of cases involving empty hand techniques and the 29% where a baton was used. There were no cases where death resulted from the use of the CEW.[v]

Studies throughout North America referred to in the Inquiry show that the incidence of injury and death both to subjects and police officers has decreased dramatically since the widespread adoption of CEWs. This tends to show that CEW use is far safer than the use of force techniques it replaced. Although there are, in the media, many stories of death **associated with** the use of CEWs[vi], in most of those cases there was no evidence that the CEW was the **cause** of death and, where it found to be, it was a contributing cause and not the only cause.

It is virtually impossible for CEWs to cause death by electrocution. Although they use sufficient current to incapacitate the subject, they use only a small fraction of the power required to stop a heart. Users are trained to avoid deploying the darts in the chest area but even where the heart

is captured by the probes it is extremely unlikely that the current deployed will be sufficient to cause death.

Specific risks relating to the use of CEWs were outlined during the evidence at the Inquiry. They should obviously not be used in the presence of flammable gases or liquids. Also, because they cause the subject to lose muscular control completely, they should not be used when the subject is elevated like Mr. Oatway was when he was standing on the desk in the pod. There is too great a risk of injury from the inevitable fall in these situations.

CEWs are not by any means risk free. They are potentially dangerous weapons and users require rigorous training. There is also a risk that a police member equipped with a CEW will use it where other, less extreme, techniques are proportionate and should be used. But studies, including the one referred to by Inspector Butler, have consistently shown that CEW deployment by a trained and certified member in accordance with the Reasonable Officer Response Model is one of the safest use of force techniques employed by law enforcement today.

Questions:

1. How do we know that Mr. Oatway was suffering from ExDS?

First, there was no indication of cause of death at the autopsy. This makes ExDS a distinct possibility in a young man since ExDs is, to a large degree, a diagnosis of exclusion.

The greater the number of the characteristics of ExDS noted above that are apparent, the greater the chance that the subject is suffering from that syndrome. Here, the evidence establishes:

- Mr. Oatway was partially disrobed
- He was not following the directions of the police
- He was constantly active and frantic
- Pain techniques had no apparent effect on him
- He would not tire
- He was displaying superhuman strength
- He was panting
- He was hot
- He was sweating profusely
- He was grunting

In addition, Mr. Oatway's methamphetamine use and struggle with mental illness puts him in the category of people more likely to be affected by ExDS.

I find there is no question that he was suffering from this Syndrome.

2. Why was it necessary to use force against Mr. Oatway at all? Why didn't the police just leave him alone until he calmed down?

This was not an option for the police for a number of reasons. When Mr. Oatway initially bolted from his cell, the CPOs and police had a legal duty to bring their prisoner back under control. By the time Mr. Oatway dove into the pod, the need to control him became even more acute. The pod was full of items that could potentially harm Mr. Oatway and others and it contained all of the electronic switches to the cells where other detainees were being held.

Most importantly, Cst. Akers realized when Mr. Oatway was in the pod that he might be suffering from ExDS. His only chance for survival would be sedation and symptomatic treatment but

sedation could only be administered if he were under control. If he were left alone, the "runaway train" of ExDS would almost certainly kill him. The application of force to control him was his best chance of being saved.

3. If a person suffering from ExDS cannot does not respond to pain, why did the police strike and kick him so many times?

Pain techniques are often an effective and reasonable way of gaining control of subjects who are actively resisting or assaulting the police. I find that these techniques were ineffective against Mr. Oatway because of his ExDS. In reaching this conclusion I have had the benefit of assessing all of the evidence with the luxury of time. The police interacting with Mr. Oatway did not.

Dr. Hall testified that even trained psychiatrists observing a person in the throes of ExDS may have trouble differentiating between ExDS and a number of other potential afflictions including acute drug intoxication and certain mental illness events. Add to that the fact that most of the EPS members applying force to Mr. Oatway were responding to the panic alert in the pod, knew nothing of Mr. Oatway and had no opportunity to observe him until they were in middle of the struggle. Even though they were trained on ExDs, they could not have been expected to conclude that it was the cause of Mr. Oatway's outburst. As such, the application of hard empty hand force was reasonable based on what they knew and observed.

4. Mr. Oatway stopped breathing within minutes of the CEW being deployed. Does this not mean that the CEW caused his death by electrocution?

"Common sense" would seem to support this conclusion. But just because one event follows another does not mean that the first event caused the second.

There are three reasons why I can conclude that the CEW was not the cause of Mr. Oatway's death. First, as previously noted, it is virtually impossible for a CEW to cause a heart to stop. There is simply not enough electrical energy deployed. Second, the evidence of Dr. Dowling as to the location of the probes from the CEW rules out the possibility of capture of the heart. Third, if he were electrocuted, his heart would have stopped within seconds of the deployment of the CEW. We know that well after a minute following deployment, he was still moving.

It is also important to remember that ExDS deaths were documented in medical literature long before the invention of the CEW. And people still died with the same frequency.

5. Was it reasonable to deploy the CEW when it was deployed?

According to the ROR model, intermediate weapons are generally a proportionate response when a subject is actively resisting or assaultive. Mr. Oatway was both. Moreover, five minutes' worth of hard empty hand application of force (punches and knee strikes) proves ineffective. Finally, Mr. Oatway was biting Cst. Carter's finger. In these circumstances the deployment of the CEW was reasonable. In fact, it would have been reasonable to have deployed it sooner. Mr. Oatway was assaultive and not following police direction even when he was in the sally port and it would have been reasonable to deploy the CEW at that early stage. Unfortunately, Cst. Akers, the only member carrying a CEW, was not present at that time.

6. If sedation is the only way to avoid death in a case of ExDS, what don't the police simply shoot the subject with a sedative dart as is done with animals?

This issue was well canvassed by Dr. Hall. Responding to ExDS must be a collaborative effort between law enforcement and emergency medical services. The amount of sedation required to deal with ExDS can result in the patient needing intubation to prevent death from the effects of

the sedative. Police officers are not able to intubate. Only EMS personnel can and, for that reason, sedation must be left to them.

As previously stated, EMS personnel are not equipped or skilled in restraining violent subjects. That task is the responsibility of the police.

7. Even if Mr. Oatway was not electrocuted by the CEW, was the deployment of the CEW not a contributing cause of his death?

Dr. Dowling testified that he could not rule out the deployment of the CEW being a contributing cause of Mr. Oatway's death. He was in extreme physical distress and any additional insult to his body be it from running to exhaustion or wrestling with EPS members or being struck by fists and knees or being shocked by the CEW could elevate that stress and increase his likelihood of death.

But this must be put into perspective given what is known about ExDS. As previously stated, any chance of avoiding death involves the prompt control of the subject and the prompt administration of a sedative. Control is only possible in a case of excited delirium if force is applied.

I conclude on the basis of the evidence I heard that **delay** in obtaining control and effecting sedation was far more likely to result in the death of Mr. Oatway from the runaway train of ExDS than any incremental increase in stress to the body caused by the insult of the application of any of the force that was used including the CEW deployment.

I conclude, therefore, that, on balance, the deployment of the CEW on a person in the throes of ExDS at the earliest possible stage generally **reduces** the risk of death.

In Mr. Oatway's specific case this discussion is likely moot. He expired within minutes after the CEW was deployed. By the time Cst. Akers deployed her CEW Mr. Oatway had most likely crossed the Rubicon and was most likely past the point of surviving the devastating effect of ExDS. He would have died whether the CEW was deployed in dry cell 125 or not.

8. Was there anything else the police could have done to bring Mr. Oatway under control sooner?

In this case I find that all of the CPOs and members of the EPS acted legally, reasonably and in accordance with policy in the execution of their duties.

As to whether anything could have been done differently, the testimony of Inspector Butler of the CPS provides insight into the somewhat different approaches taken by the EPS and the CPS with respect to the application of force.[vii] Two major differences in approach emerged from his evidence:

First, with respect to the CEW, the only EPS member interacting with Mr. Oatway qualified and trained in its use was Cst. Akers. In Calgary, largely as a result of some of the research conducted by Inspector Butler, all patrol members are trained and qualified in CEW use and all carry the weapon.[viii]

As previously mentioned, earlier deployment of the CEW, for example, in the sally port, may have increased the likelihood of Mr. Oatway's survival. That deployment would only have been possible if there were a trained member with a CEW present. Because only select officers at EPS are so trained and equipped, there was no opportunity to deploy a CEW earlier than the arrival of Cst. Akers.

Second, CPS patrol members are also trained in the use of Vascular Neck Restraint ("VNS") while EPS officers are not. A member using VNS positions himself or herself behind the subject and crooks the arm around the subject's neck. The member squeezes the arm closed to apply pressure to both Carotid arteries such that the brain is temporarily deprived of oxygen. The subject loses consciousness but is quickly revived once the pressure is removed. VNS is not to be confused with respiratory neck restraint or a "choke hold" where the passage of air through the trachea is interrupted.

Inspector Butler testified that his research in this area demonstrates that VNS is a reasonably safe way to restrain violent subjects. His own research is supported by at least one other study.[ix] Inspector Butler opined that there was a possibility that VNS could have been used effectively on Mr. Oatway, particularly when EPS members were struggling with him on the floor in the pod. Cst. Akers testified that she could not get a "clear shot" using the CEW at this that time so VNS would potentially have been a viable option.

Recommendations for the prevention of similar deaths:

I began this report by stating that Mr. Oatway's death was a heartbreaking tragedy. It had a terrible effect on all who were touched by it. For Mr. Oatway, one can hardly imagine the fear and pain he must have experienced before he died. His body and mind were out of control and, being delirious, he almost certainly did not know why all of those EPS members were fighting with him, hitting him, kicking him and shocking him. His last moments on Earth were terrifying and violent.

For his family, despite their best efforts to support their Jeffrey, he died in a way that nobody should. Their best efforts to assist him in dealing with his demons proved ineffective. The extensive use of force by the EPS in response to a syndrome that even experts have difficulty comprehending understandably caused them extreme upset. I doubt this Inquiry will satisfy them in their search for answers about his death but I hope it helps.

I have spilled a great deal of ink analyzing events taking place over a very few minutes in the APU on April 12, 2012 with a view to determining whether anything could have been done to prevent Mr. Oatway's death. Backing away from that detailed analysis for a moment I feel compelled to say that I have no doubt that he would still be alive today were it not for his use of methamphetamine which predisposed him to ExDS. The police did not kill him. Meth did. It is well beyond the scope of this Inquiry to make recommendations for reducing the abuse of this incredibly destructive substance. But anything that can be done will certainly aid in preventing deaths like Mr. Oatway's.

Previous Public Fatality Inquiries dealing with ExDS have made recommendations for increased training for police and other first responders and for increased gathering and compilation of data for research purposes.[x] In this Inquiry the evidence supports a conclusion that training of EPS members and EMS employees was adequate.

Recommendation Number One:

As previously stated, ExDS is still poorly understood due, in part, to the small number of instances of the Syndrome and the difficulty in marshalling data useful for research following such a necessarily stressful and urgent event. There are those like Dr. Hall who are hungry for more data to support research in this area. The police are very often centrally involved in cases where people die of ExDS. Therefore:

> **I recommend that the Alberta Association of Chiefs of Police ("AACP") contact Dr. Hall to determine how best to marshal and communicate any needed research data in cases of ExDS while in police custody and that any recommendations agreed to by Dr. Hall and the AACP or any of its member agencies be implemented.**

Recommendation Number Two:

Even though unlikely, it is possible that the earlier deployment of the CEW and/or the use of VNS may have increased the chances of Mr. Oatway's survival. It is not reasonable that different approaches to police use of force in respect to CEWs and VNS exist as between the EPS and the CPS. Therefore:

> **I recommend that the AACP convene use of force experts from the EPS, CPS, RCMP and its other member agencies in the Province to determine, informed by evidence and research, whether more widespread use of CEWs and VNR by those agencies is indicated.**

Recommendation Number Three:

CEW use is still very controversial. A review of news articles and publications about CEWs shows that a great deal of the controversy results from misinformation about the dangers of CEW use. Controversy has given rise to litigation and, during submissions it was suggested that the difference in CEW policy between the CPS and the EPS may have resulted from fear of litigation on the part of the EPS.

In the Provincial Guidelines for the Use of Conducted Energy Weapons issued by Alberta Justice and Solicitor General at paragraph 6(b) there is the following passage:

> "In accordance with Section 25 of the *Criminal Code*, the appropriate use of a CEW requires a balance be achieved between the safety of the police, the safety of the subjects they face, bystanders **and public expectations of acceptable police behaviour.**" (emphasis added)

Section 25 of the *Criminal Code* reads as follows:

> " Every one who is required or authorized by law to do anything in the administration or enforcement of the law
>
> **…**
>
> **(b)** as a peace officer or public officer,
>
> **…**
>
> is, if he acts on reasonable grounds, justified in doing what he is required or authorized to do and in using as much force as is necessary for that purpose."

Nothing in Section 25 references "public expectations of acceptable police behaviour." And to what extent are those public expectations formed by misinformation or the use of "common sense" as to the dangers of CEW use?

A reduction in the otherwise appropriate use of an intermediate weapon by the police based on irrelevant considerations is not without consequence. Early CEW deployment can potentially save the life of a subject if he is experiencing ExDS and cannot be otherwise be restrained. As previously mentioned, CEW use has been proven to be relatively safe compared to other police use of force techniques. And, in any case, the failure to employ an otherwise appropriate use of

force technique increases the risk that the police will find it necessary to use lethal force if the situation escalates.

Therefore:

> **I recommend that the phrase "public expectations of acceptable police behaviour" be deleted from the Provincial Guidelines for the Use of Conducted Energy Weapons and that the formulation of policy or the making of any decisions regarding the deployment and use of the CEW by police agencies in Alberta be based only on evidence and research.**

DATED March 8, 2018,

at Edmonton, Alberta.

Original signed by

Greg Lepp
A Judge of the Provincial Court of Alberta

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[i] There is debate as to whether Excited Delirium Syndrome is listed in the International Statistical Classification of Diseases, Injuries and Causes of Death.

[ii] https://www.npr.org/templates/story/story.php?storyId=7608386

[iii] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
Edited by American Psychiatric Association

[iv] ExDS is far more likely to occur in men than women.

[v] http://www.nletc.com/files/Calgary-Police-Study.pdf

[vi] Eg: https://www.reuters.com/investigates/special-report/usa-taser-911/ome

[vii] Both the EPS and the CPS operate within the confines of the over-arching Provincial Guidelines for the Use of Conducted Energy Weapons issued by Justice and Solicitor General. The Guidelines allow for a great deal of flexibility in the formulation of policy in this area by policing agencies in Alberta.

[viii] Very recently Ottawa police have decided to do the same: http://www.cbc.ca/news/canada/ottawa/ottawa-police-taser-consultation-1.4546738

[ix] http://www.physiology.org/doi/pdf/10.1152/japplphysiol.00592.2011

[x] These and all reports can be accessed at:
https://justice.alberta.ca/programs_services/fatality/Pages/fatality_reports.aspx