CANADA
Province of Alberta

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Court House

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

on the 14 - 22 & 25 days of November, 2005 (year), and by adjournment

on the 25 day of January, 2006 (year), and by adjournment

on the 23 - 25 day of May, 2006 (year)

before P. AYOTTE, a Provincial Court Judge,

into the death of (a) James Wilbert Galloway; (b) Martin Charles Ostopovich (Name in Full) 55; 41 (Age)

of (a) Sherwood Park, AB; (b) Spruce Grove, AB (Residence) and the following findings were made:

Date and Time of Death: February 28, 2004 (a) at approximately 1842 hours; (b) 1922 hours

Place: (a) on scene in Spruce Grove, AB; (b) in hospital in Stony Plain, AB

Medical Cause of Death:
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 – The Fatality Inquires Act, Section 1(d)).

Gunshot Wound to the Chest (Galloway}
Multiple Gunshot Wounds (Ostopovich)

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

Homicidal (Galloway)
Homicidal (Ostopovich)

Circumstances under which the Deaths occurred:

Corporal James Galloway and Martin Ostopovich died during a stand-off between Mr. Ostopovich and police. Armed with two rifles, Ostopovich shot Corporal Galloway when the policeman, in an effort to stop him from leaving his residence, rammed Ostopovich's pick-up truck as he backed it down his driveway. Ostopovich was then shot himself by members of the RCMP Emergency Response Team (hereinafter "ERT"). Corporal Galloway died instantly. His killer was pronounced dead at the hospital in Stony Plain shortly thereafter.

The incident began shortly after one o'clock in the afternoon of February 28th, 2004 when two Spruce Grove RCMP officers responded to a call from a resident of 119 Greystone Drive reporting that there was a bullet hole in his vehicle. Cst. Blaylock was the first to respond, followed shortly thereafter by Cst. Cherkas. Cherkas, relatively new to Spruce Grove, had been informed before he left the Detachment that Martin Ostopovich lived next door to 119 and that he had a history of mental illness which often expressed itself in extreme antipathy towards the police.

Upon investigation the two officers concluded from its trajectory that the shot had been fired from the Ostopovich residence. When Cst. Blaylock looked in that direction, she noted a hole in the screen which covered what appeared to be the kitchen window. The two officers decided that it would be necessary to talk to the people living there to determine what had happened. When they rang the doorbell, an extremely agitated Wendy Ostopovich answered and urged them not to go in. Responding to her concerns, the two police officers immediately retreated with her to their respective vehicles and left the scene.

Moving down Greystone Drive to a safer location, they requested assistance from Cst. Angus at the Spruce Grove Detachment and advised Sgt. Koersvelt in Stony Plain of the situation, he being the senior officer on duty at the time. While awaiting the arrival of these two officers, Cst. Cherkas interviewed Mrs. Ostopovich, who told him that her husband had been acting strangely since the previous night. She said that when she got home at around 10:30 P.M., he had been drinking, something unusual for him, and was agitated. He told her about voices he had been hearing; voices which were telling him she knew something about it. He had blood on his hands and began calling her names. She said she had become frightened and decided to spend the night elsewhere. When she returned home at about 6:30 the next morning, Martin was asleep on the couch in the living room. The house was very messy, so she spent the morning cleaning up. Her husband got up around noon. He was still agitated and told her the voices were talking to him. He said that they wanted him to kill someone, but he was resisting them. At one point he pointed his index finger at her, thumb up as though it were a gun. She explained that was the reason she had acted as she did when the two officers came to her door.

Mrs. Ostopovich also confirmed that there were two high-powered rifles in the house, one with a scope. She told him they were in the bedrooms at the back; that her husband did not have a police scanner and that the front door was the only exit. She reminded the constable that her husband did not like the police and that he had previously spent two weeks in a mental hospital. Although it is unclear whether she told this to Cst. Cherkas, Mrs. Ostopovich testified at the inquiry that it was her husband who had said to her that the police were at the door; instructed her to answer it and then headed for the bedrooms where the guns were stored.

When Sgt. Koersvelt arrived at the scene, he was brought up to date by Cst. Cherkas before he spoke to Mrs. Ostopovich himself. During that conversation, she explained to him that her husband had been diagnosed as "paranoid delusional" and was not taking his medications. She also gave him their home telephone number.

The sergeant decided to have a look at the scene himself before doing anything further and in the meantime directed Constables Blaylock and Cherkas to stop any traffic headed into the area. When more assistance arrived, it was decided to move Mrs. Ostopovich to the Spruce Grove Detachment and to contact Victim Services to assist her. Cst. Cherkas escorted her there and he recalls that on the way a message came over the police radio that Martin Ostopovich had contacted CFRN, a local television station, and told them that "someone was going to die today", causing his passenger to become "somewhat hysterical" and begin crying.

As a perimeter was being set up in the area around the residence, Sgt. Koersvelt drove by the cul-de-sac to confirm the positions his officers had taken north of the residence. On his way back he noticed what appeared to be a black tube pointing upwards out of that window with the torn screen, although no person was then visible. He accordingly took up a position southwest of the cul-de-sac where he could maintain surveillance of the house. From there he saw Ostopovich moving about the kitchen. Concerned for the other residents of the cul-de-sac, Koersvelt ordered that they be contacted by telephone and advised to remain in the basements of their homes until the incident was resolved.

Shortly thereafter central telecommunications contacted him to advise that Ostopovich was on the line. The sergeant had the call transferred to his cell phone. His caller was extremely agitated during the brief conversation which followed, calling him a "fucking rat" and asking why they had taken his wife. Attempts to reason with him were unsuccessful and eventually he hung up. During their conversation Ostopovich said he was going to take out the next person he saw, whether it was a neighbour or a policeman.

Faced with these threats, Koersvelt decided it was time to bring the ERT team in. He made the request and was told they would be there at about 4 P.M. In the interim he decided to call in more support from the Stony Plain Detachment to provide increased perimeter security and made arrangements to lock down Ostopovich's telephone so that he could only contact the police. He also spoke to the person at CFRN who had taken the earlier call. That person confirmed the threat to kill someone that day and described the caller as "being out there".

While awaiting the arrival of the ERT team, Koersvelt continued surveillance on the residence in an effort to keep the perimeter informed of any change in circumstances those officers needed to be aware of. He could see their suspect moving about the house. Of more immediate concern was the fact that he also exited twice: once to put something in the garbage; the second time to go briefly to his truck. The sergeant was also made aware that he was making abusive calls to telecommunications and making threats to come down to the Spruce Grove RCMP Detachment. At around 3:55 P.M., seeing no more movement about the house, Sgt. Koersvelt decided to try to initiate telephone contact.

He was successful and there followed a 25-minute telephone conversation during which Ostopovich continued to be very agitated and irrational: threatening numerous times to leave the house and go down to the detachment and asking once to speak to his wife "to say goodbye". It was clear to Koersvelt that the man was very paranoid and felt that everyone was against him, especially the police, the military and the government. During one of his outbursts he called the sergeant a liar and said he was "going to take the war to you". He also accused the Hell's Angels of working for the police and threatened "to hurt someone before he goes". At one point he was screaming so loudly that the sergeant could hear him from a block away without the aid of the telephone. Finally he hung up the phone again.

The two ERT negotiators had arrived about half-way through that call and were able to hear Koersvelt's part of the conversation from that time on. After Ostopovich hung up on him, the sergeant briefed the two incident commanders present, the ERT team leader and the two

negotiators about everything that had happened and then turned responsibility over to them. Cst. Pearson was the ERT team leader. His first order of business after having been briefed was to reconnoiter the Ostopovich residence with his two element leaders and Cst. White, the sniper most familiar with the area. What they saw caused them some concern. The house was tucked in very close between two others in such a way that its occupant had a panoramic view of the whole cul-de-sac from the kitchen window, making it difficult for the assault teams to get very close to the residence without being seen and even more difficult to place snipers in an advantageous position.

Ultimately it was decided to place Cst. Vigor's team on the west side of 123 Greystone Drive and S/Sgt. Konowalchuk's team on the east side of 119 Greystone Drive, that is, on the far side of each of the houses flanking the suspect's house. The disadvantage for both teams was that neither could actually see the residence and therefore had to depend on radio transmissions from the snipers to find out what was happening.

For their part the three snipers were only able to safely deploy on two sides of the house. Cpl. Christianson stationed himself to the north on the roof of the house immediately behind the residence, giving him a clear view of the entrance when he raised his head above the peak of the roof. Constables O'Neill and White, after some position changes, ended up together behind a fence in a yard across the road and to the southwest.

The difficulties their positioning presented and the significance of the inevitable delay in getting information from the snipers became apparent during the negotiations between Mr. Ostopovich and Cst. Wilkinson, the primary negotiator. At one point, in response to the latter's comment about the music playing in the background, the suspect came outside unarmed, went to his truck parked near the door, retrieved a CD and got back into the house before either of the assault teams could react. Cst. Pearson, listening on the dedicated ERT radio frequency from the command post, realized then that Ostopovich's vehicle was very close to the door and that he could access it quickly. Given that the man had repeatedly said that he was going to go down to the Spruce Grove Detachment to confront police there, Pearson became concerned about what they would do if he attempted to carry out that threat.

He considered and dismissed a number of options. The first was to have the snipers shoot out the tires on the suspect's pick-up truck. He concluded that the positioning of that vehicle would prevent them from hitting the front tires, thus leaving only the two in the rear flat. He also knew that shooting out a vehicle's tires would not disable it, but only make it more difficult to drive. He then considered having Cpl. Christianson put holes in the engine block with a high-powered, suppressed (silencer-equipped) .308 rifle. Unfortunately, he discovered that the only one available to his team had been sent out to Regina for repairs.

Given the large open area at the entrance to the cul-de-sac and Ostopovich's panoramic view, blocking it off was impractical, as was parking a vehicle immediately behind the suspect's pick-up so that it couldn't back out of the driveway. Even if by luck that could be done without their suspect seeing it, he realized that the pick-up was a well-equipped four-wheel drive machine with large tires which could just as easily be driven forward through the small fence it was facing and out the back alley. There was also the very real risk that Mr. Ostopovich would see the maneuver and be set off by it.

Ultimately, Pearson concluded, after a discussion with Cst. Vigor, that the most feasible plan was to ram the vehicle if Ostopovich tried to leave, thus disabling it and hopefully stunning the man enough to allow the team to take him into custody safely. He did so knowing his men had limited training in ramming vehicles and had never tried a maneuver like this one. In his words at the inquiry, "This move was a bit of a desperation move, but I saw no other way." It was understood that Cst. Vigor, the leader of the element charged with carrying it out, would "fine tune" the details

of the ramming plan and then seek approval from Pearson and the incident commander, Inspector Williams.

In addition to himself, Vigor's element consisted of three other assaulters and Cpl. Galloway, one of two dog handlers who routinely accompany the ERT team. The group discussed what type of vehicle to use and Galloway volunteered his. It had the advantage of being right at the scene and had a winch on the front which enhanced its ramming capability. It also obviated the necessity of sending someone away from the scene to retrieve another vehicle.

Cst. Vigor then had to decide who was going to drive the vehicle. The element leader noted in his testimony that the situation was unusual. Ordinarily when vehicles are stopped on a highway, the operation is pre-planned and one of the snipers drives the take-down vehicle because they are not needed as observers in that situation. That was impossible here because the snipers were the "eyes" of the two teams, charged with letting them know if and when Ostopovich left the house and whether or not he was carrying weapons. They were also required to maintain their positions in case he posed an immediate threat to either a member of the element teams or to a civilian and a shot was required. A member on perimeter duty volunteered to drive the vehicle, but Cpl. Galloway, a veteran of ERT operations, insisted on driving it himself.

Cst. Taniguchi was assigned to accompany him in the vehicle as cover man. Armed with an MP-5, his task was to protect Galloway during and immediately after the ramming. Both were instructed to leave their vehicle immediately after it disabled Ostopovich's pick-up and move to its rear for protection. Cst. Vigor made it clear to Galloway that he wanted him to T-bone the other vehicle, that is, hit it at or near the driver's door in hopes of at least stunning the driver. Although he was aware that there were other vehicles parked at or near the end of the driveway, in view of the distances involved Vigor felt that the suspect's truck would probably have cleared them by the time impact occurred.

As this "Immediate Action Plan" was being developed, negotiations were on-going between Ostopovich and Wilkinson. The constable had two long, generally fruitless, conversations with their suspect. Given his training, the negotiator concluded that the man he was dealing with was a "High Risk Individual", that is, someone who would be very difficult to bring back to equilibrium. Using Wilkinson's words at the inquiry, these sorts of people are in a condition where their "stressors have got to a point exceeding (their) capacity to cope with them."

During the second call, which lasted about 35 minutes, Ostopovich talked repeatedly about confronting police, using phrases like "I'm going to take it to you" and near its conclusion referred to "suicide by cop". When the subject of surrender was broached, he immediately responded with a threat to go down to the Spruce Grove Detachment and shoot it out with police. Wilkinson, realizing that his attempts to build up a rapport with the suspect were having little success, terminated the call with a promise to call him back.

At about that time Cpl. Campbell, the negotiator who had been interviewing Wendy Ostopovich at the Spruce Grove Detachment, returned to the command post. There followed a discussion among Wilkinson, Campbell, team leader Pearson and Inspector Williams about whether to tell the barricaded man that the ERT team was on site. Wilkinson was afraid that he would hear about that on the radio or television, especially since they were now in the 6 o'clock evening news time period. He had two concerns. The first was that the knowledge that he had not been told about their presence during negotiations would destroy any bit of rapport and trust Wilkinson had been able to establish with Ostopovich.

The second was slightly more complicated. The negotiator had concluded after those two long conversations that some tactical intervention was probably going to be necessary. To try and achieve a safe surrender, Wilkinson felt it was important that he control the introduction of the

ERT information. There was still the slim hope that, confronted with the presence of the ERT team, Ostopovich would reconsider his position and agree to surrender. In that case Wilkinson would be able to work with him to determine how that surrender would be accomplished. The group also understood that the knowledge that ERT was present might cause their suspect to make good his threats to confront police. After some discussion they agreed that Wilkinson should tell him about the ERT team.

Wilkinson made that fateful call at 6:14 P.M. It did not have the effect they had hoped for. Martin Ostopovich hung up the telephone and Cpl. Christianson, the sniper on the roof, saw him leave the house holding two rifles by the barrel, one in each hand. He immediately went to his pick-up truck, got in and after some initial difficulty, got the vehicle started and began to back down the driveway. By this time Vigor's team had been alerted and in accordance with the Immediate Action Plan which had been developed, he gave Cpl. Galloway the signal to ram the Ostopovich vehicle.

Unfortunately, the resulting impact did not topple it as they had intended, primarily because it became wedged against two other vehicles parked near where the collision occurred. Cst. Taniguchi, the cover man, remembers starting to open the passenger door and seeing a rifle leveled at him by Ostopovich. He crowded down under the console for protection, took his MP-5 off safe and fired one or two shots through the windshield at the man. Meanwhile, Cpl. Galloway had opened his driver's door and headed toward the rear of the vehicle as planned. He was shot in the back by Ostopovich as he did so and died almost instantly. Seeing their fellow officer fall, Cst. Vigor and his team, approaching to make the arrest, returned fire, as did Cst. White, the sniper positioned to the southwest of the cul-de-sac. Ostopovich was hit by at least twelve rounds and ultimately died of loss of blood at the Stony Plain Hospital.

Although Emergency Medical Technicians arrived within minutes of the shootings, they were unable to save either man. Dr. Bannach, the Assistant Chief Medical Examiner, testified that Corporal Galloway died almost instantly and that Mr. Ostopovich could only have been saved if a blood transfusion and surgical intervention had occurred within 5 to 10 minutes of the shooting, neither of which services can be provided by Emergency Medical Technicians.

Recommendations:

Against the foregoing factual background, a number of concerns were raised by the parties participating in the inquiry. I examine each of them in turn.

1. Tactics

Understandably, the tactics used by police during the stand-off were the focus of many questions at the inquiry. Generally, those questions explored three issues:

1. The decision of the negotiators to inform Mr. Ostopovich of the presence of the ERT team without first seeking outside opinions from a psychiatrist, a psychologist or his wife regarding the effect that knowledge would likely have on him.

2. The choice of an Immediate Action Plan which called for the ramming of the suspect's vehicle with Cpl. Galloway, technically not a member of the assault team, as the driver of the ramming vehicle and the concurrent decision to have the corporal and his cover man leave the vehicle after the ramming took place.

3. The proper role of a sniper in ERT operations and the related question of when lethal force is justified in a police stand-off. That issue arose as the result of Cpl. Christianson's evidence that he saw himself primarily as an observer and communications person.

I intend to make no comment on those decisions, other than to say that credible reasons were given for the choices which were made. Every incident in which an ERT team is involved is unique. Team members, whether they be incident commanders, team leaders, snipers or assaulters, are routinely called upon to make quick decisions, often with incomplete information about the person or persons with whom they are dealing. Given those realities, it would be inadvisable to hamper their work with a long list of guidelines restricting acceptable responses in every situation. ERT teams are elite units in the sense that they are specially trained and specially equipped to respond to situations beyond the resources of standard police forces. Their effectiveness will always depend on the application of their intelligence and training to any given situation. If they are unduly shackled with policies that neutralize their ability to adjust to the almost limitless scenarios they will face, we run the real risk that they will be ineffective when a flexible response may be what is required to achieve the result we want.

I understand that the approach I describe will mean tragic consequences in some circumstances, but it will also mean the successful resolution of some crises that would otherwise end badly. When tragedies do occur, it would be a mistake to assume that the blame must inevitably fall on those who had the greatest resources. There are at least two players in police stand-offs and one of them is, almost by definition, unpredictable. That was the case here. Given the abundant evidence of Mr. Ostopovich's apparent determination, as the result of his mental illness, to confront police and bring about his own death, there was nothing in what I heard to suggest that a less tragic result would necessarily have been achieved if different decisions had been made. As at least one counsel observed during his submissions, "Hindsight is always 20-20."

While I do intend to make recommendations respecting the composition, training and equipment provided to ERT teams, it should be understood that at best they can only reduce, not eliminate, the possibility that future deaths will occur during ERT operations. There will always be too many human variables at play during these kinds of confrontations to ever guarantee a happy result, no matter how hard we may try.

Having said that, one recommendation concerning the tactics employed by ERT teams *is* appropriate. The RCMP Tactical Operation Administrative Review ("the Tactical Review") of this incident expressed some concern about Cpl. Christianson's understanding of his role as a sniper. At p. 45 of that document, the following appears:

> 6. S10 comments suggesting his job was to provide commentary … basically as a sniper, I'm not expected to take a shot …, cause the Review Team concern. It may be S10 has not accurately articulated his role as a sniper. Comments included in this statement suggest to us that he was not mentally prepared to use lethal force. From S10's statement, we were not able to determine if this comment is out of context, or if it accurately describes S10's understanding of his assignment.

In his Memorandum commenting on the Tactical Review, provided to me as part of the same exhibit, Superintendent Jay expresses the same concern at p. 6 when he says, "S10's comments as to his role being to provide commentary only is also quite troublesome."

To the extent that those comments express regret that Cpl. Christianson did not fire at Mr. Ostopovich when he last left the house carrying two rifles by their barrels and to the extent they

suggest that the present restriction on the use of lethal force should be made more flexible to allow police snipers to end an incident when the opportunity arises, they are ill-founded and contrary to our society's tradition of respect for every human life. While I acknowledge that neither of those concerns may have been the reason for the comments which were made, I nonetheless feel it important to emphasize both the wisdom and the importance of the present policy and training with respect to the use of lethal force.

Having heard the evidence of Cpl. Christianson, I am satisfied that he acted appropriately and was well aware of the part he had to play on the ERT team. In emphasizing his task as an observer and commentator, I understand, as the authors of the foregoing documents may not have, that he was simply trying to explain the uniqueness of a situation where, because of the physical layout, he was the *only* member of the team able to see what Mr. Ostopovich was doing and that, accordingly, his communications role became paramount.

One of the things which shone through the evidence of all the members of the ERT team was their dedication to resolving incidents such as this without the loss of life. That concern was obvious in the testimony of Cpl. Christianson, who responded with these words to one of my own questions about why he didn't consider shooting Mr. Ostopovich when he left the house, "If I shot him in the back, I don't think society would condone that behaviour, so I wouldn't take that shot." That understanding of the onerous duties cast upon ERT team members can only promote for them the respect of the public which they serve. Any change in policy or training which might reduce that respect is in my view undesirable.

I THEREFORE RESPECTFULLY RECOMMEND that the RCMP maintain its existing training and policy restricting the use of lethal force to situations where the suspect poses an immediate threat to police or civilians, has the means to carry out that threat and demonstrates the intent to do so.

2. Emergency Response Teams

a. Priorities

In explaining the challenges involved in creating, equipping and maintaining ERT teams, Chief Superintendent Walter Kamins made this observation: "It comes down to balancing priorities." I agree and the evidence presented at the inquiry leads me to believe there is a need to reassess those priorities as regards ERT teams. In saying that, I make it clear that I understand that my role under the *Fatality Inquiries Act* ("the *Act*") is to recommend and appreciate that the responsibility for allocating financial resources rests, as it should, with our elected representatives.

Section 53(2) of the *Act* permits recommendations "as to the prevention of similar deaths". In what follows I have considered the composition, training and equipping of ERT teams in a wider context, recognizing that they are called upon to deal with many different kinds of emergencies, not just those involving one mentally disturbed man barricaded in his home. From my own judicial experience they include such things as assisting in the dismantling of increasingly sophisticated marijuana grow operations and in combating other forms of organized crime. In the present world political climate one can also foresee the reasonable possibility of their having to deal with attempted terrorist activities like airplane hijackings. In short, the challenges confronting the effective use of ERT teams without a concurrent loss of life are becoming more varied and more complex. In that context I have concluded that these recommendations must take into account that wider reality to be of any value.

What I heard at the inquiry convinces me that the conundrum facing those ultimately responsible for maintaining and financing ERT teams is whether it is better to continue along the present

path and react only when the problems become more severe or to look to the challenges we know we will face in the future and begin preparing to meet them now. In assessing that problem it would be wise to remember that incidents requiring ERT intervention are on the rise. Chief Superintendent Kamins estimated an increase of 20 calls per year. Sgt. Paul Whattam, the ERT co-ordinator for Alberta, testified that, "You have to remember we have probably three of the busiest part-time emergency response teams in the country … in the RCMP. I've heard that from Ottawa, from the people who do keep score." Later on when he was asked about his ability to squeeze in more scenario training for ERT teams, he cautioned, "We have such pressures on our members right now that for them to maintain their sanity, we have to draw a line somewhere." At least some of those pressures must surely be related to the fact that ERT team members must also carry out a full schedule of regular police duties.

Whether we like it or not, we live in an age of rapid technological advancement where those so-inclined have, despite our best efforts, increasing access to more sophisticated and powerful weaponry. We can expect then that ERT teams will be confronted with predictably more complicated and dangerous incidents requiring a high level of skill and training and equipment which matches, or ideally exceeds, the resources available to those they are asked to control.

All of those factors should impact the choices to be made and I have attempted to keep them in mind in making the recommendations which follow, recognizing again that the difficult task of choosing priorities is left, as it should be, to those in a better position than I to carry it out.

b. ERT teams

i. Full-time/part-time

There are three ERT teams in Alberta, based in Calgary, Red Deer and Edmonton. They are all part-time teams, meaning that every member of the team has other regularly assigned duties and is called away from those duties or from off-duty personal activities when a request for ERT team services is made.

The weaknesses of such a system became apparent during the inquiry. Detachment commanders complain when members are taken from their regular duties for training or to respond to call-outs, some of which can be quite drawn out. The inevitable result is either a reduction in local policing manpower or the need for another member to work overtime filling in for the missing ERT team member.

Having other duties also means that sometimes a team member will be coming to a crisis scene nearing the end of or having just completed another shift, including sometimes a night shift. To further complicate matters, the inevitability of transfer and promotion makes it difficult both to assemble a cohesive team and to maintain a full complement of team members. When he testified, Sgt. Whattam noted that two of the three ERT teams were at that time one short of the full12-member complement. He added that the usual problems caused by the transfer or promotion of team members are compounded by the high qualifying standards prospective ERT team members have to meet. Cst. Taniguchi, the striker (trainee) involved in this incident, provides an example of that difficulty. Having initially qualified and completed a portion of ERT training, he was subsequently transferred to Brooks, Alberta, making it impractical for him to continue as an ERT team member given the time and distance involved in responding to call-outs, even as a member of the Calgary team.

The part-time model is particularly hard on team leaders and their seconds-in-command, who are given numerous additional administrative duties, so many that they often have to use days off to complete them. Randy Pearson, the ex-RCMP member who was Edmonton team leader during the Ostopovich call-out, listed the following as *some* of his duties: make sure equipment is

in order, requisition new equipment as needed, arrange repair of malfunctioning equipment, maintain equipment inventory, maintain office supplies and office equipment, ensure division reports are completed and stored properly, make sure squad jobs are completed, research available equipment and buy where possible, obtain training sites and act as liaison with private site owners, recruit and test new members, conduct bi-annual tests of team members to ensure physical standards and weapon proficiency standards are maintained, act as the liaison member for the radio-tech people.

On the other hand, creating full-time ERT teams presents its own challenges. As Chief Superintendent Kamins explained, the option is either to reduce the present strength of local police detachments if present staffing levels are to be maintained or create and fund new positions. His view at the inquiry was that, at present, government was more supportive of putting more policemen on the streets than in providing more "support positions", as specialized units like ERT teams are labeled. He noted as well that there are problems staffing full-time teams because their members do not have the same career development and advancement opportunities as regular members.

Despite these problems, considering the increased workload and more complex nature of the work involved, to which I have already referred, I am of the view that a resort to full-time teams is inevitable and that serious consideration should be given to starting that process now.

I THEREFORE RESPECTFULLY RECOMMEND that as a first step to the eventual formation of full-time ERT teams, two full-time positions per team be created, being team leader and second-in-command, to be primarily responsible for the recruitment of prospective team members and the arrangement and provision of on-going team training in addition to their regular duties as team members. I further recommend that, in consultation with RCMP management, attempts be made to enhance the career development opportunities of those positions as a means of attracting high quality candidates.

ii. Team Composition

Presently, an ERT team has 12 members: a team leader, three snipers and eight assaulters. The team is allotted two 10-hour training days per month except for snipers, who now get a third day each month.

The Tactical Review recommended the creation of 20-man teams. Sgt. Whattam indicated that efforts are presently under way to increase team numbers to 15, but that problems are being encountered for the usual reasons, i.e. – transfers, promotions, high qualifying standards. Despite those difficulties, larger teams would go a long way to ensuring an adequate team response even if some team members are away on holidays or unavailable for other reasons. They would also minimize the need to call out members who have just completed night shifts or other longer-than-normal regular duty hours. The resulting larger talent pool should also make it easier to staff full-time teams if the decision is ultimately made to create them. Once the trained manpower is available, policy makers would also have the option of creating smaller full-time teams to be supported by an additional roster of part-time members. A system might even be created whereby a member could serve a specified term as a full-time member and then move to part-time status or *vice versa*. During extended call-outs, larger teams would permit flexibility in the deployment of team numbers so that relief would always be available as needed.

I THEREFORE RESPECTFULLY RECOMMEND, notwithstanding the difficulties involved, that part-time ERT teams be gradually increased to 20 members. To maintain continuity, it is also recommended, so far as reasonably possible, that the transfer of ERT team members be confined primarily to areas in close-enough proximity to their present posting to enable them to maintain their ERT-team duties or to areas which would enable them to serve with one of the

other provincial ERT teams, thus ensuring a maximum return on the time and expense involved in their training. While I understand that the question of promotion presents special difficulties, efforts should be made to give some priority to ERT team candidates who are otherwise qualified when promotion opportunities become available in the areas where they are presently posted or where other ERT teams are based. Finally, I make it clear that the numbers I recommend do not include specialized support staff such as dog handlers, negotiators and communications personnel.

iii. Team training

The need for more training time was one of the themes which ran through the inquiry. While the creation of full-time teams would largely solve that problem, I recognize that goal, if it becomes a reality at all, will only be achieved over time. In the interim, provision should be made for adequate training time for the part-time teams now in existence. I heard compelling evidence that such time needs to be increased.

Sgt. Whattam referred in his evidence to the extra pressures on team members when even more training is squeezed into the time presently allotted. Mr. Pearson made it very clear in his testimony that it was virtually impossible for team leaders to adequately discharge their duties without devoting extra time to that task on their days off. Cst. Vigor, the present Edmonton team leader and a man more given to understatement than exaggeration, gave the following description of the training tasks that need to be covered in the time presently allotted:

> I have a list of the things we do. In those two days of training we have physical standard testing, firearm qualifications, tactical chemical munitions, less lethal interventions, noise, flash/bang diversionary devices, ballistic shield training, advanced police defensive tactics, judgmental decision-making, bush search techniques, close-quarter combat training, high risk vehicle intervention, breaching, tubular (i.e. – airplane) assault, helicopter insertion and extraction, … ladder techniques, tactical rappelling, downed officer/citizen rescue, close personal protection, SCBH ("self-contained breathing apparatus") tactical operations, NCRB ("nuclear, chemical, radial, …and biological") operations.

Not surprisingly, he concluded that portion of his testimony with this observation: "So you can see (with) two days training per month we have to spread our training very thin."

One must also remember that the Edmonton ERT team covers most of the northern half of the province and accordingly must deal with both rural and urban incidents, the approach to which presents different types of problems and involves the implementation of diverse responses often requiring specialized skills and tactical maneuvers.

Contrary to Chief Superintendent Kamins' stated understanding of the situation, Sgt. Whattam noted that he gets a lot of complaints from ERT team members regarding the training time available. By way of contrast, he testified that the Edmonton Police Service tactical teams, *which are full-time units*, devote 23 to 24% of their time to training. He did say that "It's getting better, but could get better." As the man primarily responsible for ERT teams in the province, he concluded that "I think they need more training time."

Mr. Pearson referred to the valuable assistance he received from time to time from the Edmonton Police Service Tactical Teams, all of whom may be called upon from time to time to assist ERT teams in responding to incidents near the city when more manpower is needed. This is in my view a valuable resource, the use of which should be encouraged. Joint training sessions from time to time, as suggested by the Galloway family in its submissions, would be both beneficial and cost effective as promoting a sharing of both training resources and

experience.

I THEREFORE RESPECTFULLY RECOMMEND that training time for ERT teams be increased initially to three days per month and that policy makers be prepared, after a review with the teams themselves of the impact of that change, to increase the time allotted to four days per month if warranted. I also recommend that annual "cross-training" with the Edmonton Police Service Tactical Units be pursued and that any additional funding and training time which may be required be provided. I further recommend that dog handlers, being intimately involved at the front line in most incidents, be required to attend all ERT team training sessions and that other support personnel such as communications people and negotiators participate in training sessions where their involvement is deemed important to the achievement of the specific goals of that particular session. Finally, I recommend that incident commanders be required to participate in sufficient training sessions to enable them to work with and become familiar with team members and the level of skill they possess and to enable team members to become familiar with their commanders and the duties they are required to discharge.

Although it will be dealt with elsewhere in a slightly different context, I prefer to deal now with mental health training for negotiators. Although technically not members of ERT teams, negotiators are clearly vital to the critical incident response process. They are the ones most likely to be in direct contact with the suspect and will often have a critical influence on the outcome of the incident itself. Considering the high percentage of people with mental health issues involved in these confrontations, it is important that special care be given to mental health issues in negotiator training courses. While the subject was not thoroughly explored at the inquiry, Cst. Wilkinson, the negotiator involved here, suggested in his testimony that such training was cursory at best. Dr. Patrick White, in discussing the creation of the new Police and Crisis Teams (PACT) now available in the City of Edmonton to respond to mental health emergencies, indicated that the police officers assigned to those teams receive extensive mental health training. Those involved in negotiations in high risk situations should have, at a minimum, similar training.

I THEREFORE RESPECTFULLY RECOMMEND that negotiators assigned to Alberta ERT Teams be provided at a minimum with the same mental health training now provided to PACT team police officers in the City of Edmonton.

It was also submitted by Mr. Davison, counsel for the Ostopovich family, that I recommend that either psychiatric or psychological resources be made immediately available to ERT negotiators and ERT team commanders. I do not do so. While as a society we have what may be an unhealthy reliance on the opinion of so-called experts (some reading this report may think I am an example of that malaise), I am satisfied on the evidence that I heard that such reliance in the high-charged atmosphere of a critical incident response would be counterproductive. Paradoxically, I rely for that conclusion on the evidence of the expert Dr. White, a witness I found learned, practical and compelling.

When asked that very question by Mr. Davison, he responded with these words:

> … I'm not so sure that would be the case. I mean you're into an advanced situation at that stage and that's where I'm not so sure a psychiatrist would be involved. I think a trained negotiator who is obviously experienced in these situations would be the appropriate thing to do. Psychiatrists, I mean we're trained to diagnose, assess and treat psychiatric illness but we're not trained negotiators. We might come across that way sometimes but we're not; we don't have those skills in that situation and invariably if you've got somebody who is extremely paranoid, it may actually very well inflame the situation and you know that can happen as well depending what the nature of the delusions are. .... Do I

> believe a psychiatrist should or could be valuable in that situation? I would have to say no.

In the final analysis, then, I believe the emphasis should be on prior training, not the provision of on-the-scene resources which might unduly, and fatally, complicate the situation.

iv. Medical support

Although it would not have made any difference in the unique circumstances of this incident, the presence of emergency medical services at ERT incidents will often be crucial to preventing deaths. Despite that, Sgt. Whattam cogently explained the difficulties involved in arranging to have such services available. In smaller communities like Spruce Grove existing resources make it impractical to expect local Emergency Medical Services to guarantee the presence of an ambulance at the scene of every call. Sgt. Whattam testified that he is in negotiations with the Edmonton EMS to have one of their paramedics accompany the Edmonton ERT team on every call-out in an effort to solve that problem. That dedicated paramedic would ideally be available on training days as well. That is an initiative which should be encouraged.

I THEREFORE RESPECTFULLY RECOMMEND that, if necessary, extra funding be made available to enable a contracted paramedic to be added as a support person to every ERT team and that he or she be provided with the funding and time to train with that team.

v. Equipment

Happily, many of the equipment concerns which came to light during this incident have been or are being dealt with. The old protective vests which were incapable of stopping a high-powered rifle shot will shortly be replaced by ceramic body armour which has that capability. A new mobile command centre has been designed to replace the cramped, poorly-equipped one in use during this call-out. I understand that this vehicle has been approved by the RCMP as the national model and will be provided to all three Alberta ERT teams. New and more sophisticated night vision equipment, important to ERT teams called upon to respond to incidents in poorly lit rural areas, is being purchased. However, in an age of ever-changing innovation and advances in weaponry, it is important that ERT teams be kept constantly supplied with up-to-date equipment.

I THEREFORE RESPECTFULLY RECOMMEND that there be an annual review conducted by RCMP management to ensure that ERT equipment is keeping pace with what has become available on the street and that government be prepared to provide extra funding, if required, to purchase any up-graded equipment which might become necessary to achieve that goal.

One item of equipment which would almost surely have prevented the death of Corporal Galloway is an armoured personnel carrier. The presence of such a formidable vehicle might also have convinced Mr. Ostopovich to surrender, although that is less certain. I was told by Sgt. Whattam that the purchase of such an expensive piece of equipment falls outside of the usual budgetary process and must be specifically approved by the province. Chief Superintendent Kamins testified that preliminary discussions were under way and that if other concerns could be adequately addressed, the RCMP, with provincial approval, would look to the purchase of two such vehicles for the province. One of those other, non-budgetary concerns involved the question whether the public would accept the presence of military-type vehicles on its streets. He made it clear, as do I, that that must ultimately be a government decision as it is the government which is ultimately responsible to the public.

Having said that, the utility of an armoured vehicle in incidents like this one was most apparent at the inquiry. Remembering that an armoured vehicle would not likely be required in every call-out

and considering the expense involved, it would be in my view uneconomical and impractical to have one as part of every ERT team's arsenal. It would rather be more appropriate to have at least one available as needed.

I THEREFORE RESPECTFULLY RECOMMEND that if non-budgetary issues do not preclude such a purchase, that at least one armoured vehicle be acquired and kept at a central location so that it could be transported upon request to any of the Alberta ERT teams. Given the geographical realities of the province, the need for maintenance and the possible difficulties involved in transporting such a vehicle over longer distances, it would be ideal, funds permitting, if two such vehicles could be purchased.

3. Mental Health Issues

a. Introduction

The most tragic aspect of the events which spawned this inquiry is the knowledge that the incident itself, and the deaths which resulted, might well have been avoided if Martin Ostopovich had received the treatment he needed for the mental illness which had taken hold of him. The history of that illness and the inability of the mental health system to adequately deal with it bring into stark relief the difficult challenges confronting a society which must attempt to balance the need to ensure that those with mental illness receive adequate treatment against the right of those very same people to withhold their consent to that treatment. If we do not find an acceptable compromise, the inevitable consequence will be the sadness and suffering of those who care most about the patient and sometimes, as occurred here, unnecessary deaths. There will be added to that tragedy the inherent social cost of disillusioned family members, frustrated and angered by their inability to access proper treatment for their loved ones. In the end, if we do not deal with the problem, our very credibility as a caring society is brought into question.

b. The magnitude of the problem

In rather startling testimony, Dr. Patrick White, a trained psychiatrist himself and a man who gave evidence as the Regional Program Director for the Edmonton Capital Health Region, said that 34% of those who live in the Edmonton area meet the criteria for mental illness. Of that number 50% will have, in his words, "some major emotional event in their lifetime". This is how he characterized the situation:

> The prevalence of psychiatric problems, emotional disorders, in society is extremely high. Unfortunately, sometimes it goes unrecognized and unfortunately we have the stigma element with some of the more chronically medically ill where we have patients who really don't want to admit that they're mentally ill because of the consequences. I had a patient recently (who) was afraid to say that she had a schizophrenic illness because she thought her job would be at risk.

Elsewhere in his evidence Dr. White drew a more graphic picture of the difficulties we face:

> The number of psychiatric consults done at the Royal Alexandra Hospital last year was 4000; 3800 at the University of Alberta Hospital. And the Misericordia and the Grey Nuns are not far behind. The suicide rate in Alberta: 40% of those occurred in the Edmonton Region in 2003. And the number was 136; 128 in Calgary. The suicide rate in young males, suicide rate in male children, has quadrupled in 25 years. And we just actually went through these figures recently. Thirty-four percent of Edmonton adults meet the criteria for psychiatric illness. Twenty percent have substance abuse disorders. … In Canada 10.2% of

> communicants use crack cocaine or cocaine; 4.1% use ecstasy. In Alberta it's 12.3% and 6.5% respectively. We don't have figures on crystal meth as yet, but if you look at the number of assessments we're doing, the number of patients who are being admitted. If you look at the police reports, it is rising exponentially quite seriously. And each psychiatrist in this region has invariably one or two young people psychotic, aggressive and addicted to crystal meth at this very point in time. And depression is the third highest cause of disability in Canadians. And the overall burden of psychiatric illness on the Canadian economy on a yearly basis is 14.4 billion dollars. If you look at cost of treatment versus loss of productivity, because unfortunately schizophrenia hits people in their early 20's, more severe ones present at a much earlier age. If you throw in substance abuse, then the incidence is much higher. So that we're certainly extremely busy.

c. Resources

i. Physicians

Those alarming statistics and the burgeoning crystal meth problem in this province, evidence of which I see regularly as a sitting judge, make it clear that the pressure on our mental health resources is increasing drastically. The problem is not just increasing access to the system but also providing sufficient numbers of properly trained people to deal with the heightened demand for services.

Dr. White testified that numbers in this province are down so substantially that we need 70 to 80 more qualified psychiatrists immediately. In the Edmonton area 15 are needed, 9 immediately. For the area where this incident occurred that increase would mean the availability of two visiting psychiatrists per week instead of two twice per month. The issue, as he sees it, is less a question of training or spaces than it is of attracting people to the specialty and keeping them here once they are trained.

In the recent past government has publicly gone to some lengths to attract other specialists to the province in order to create world class facilities in other health areas. Given the magnitude of the mental health problems in Alberta, similar efforts would be appropriate to attempt to cope with those problems.

IT IS THEREFORE RESPECTFULLY RECOMMENDED that the Government of Alberta, in consultation and co-operation with the University of Alberta Faculty of Medicine, provide funding for a recruiting campaign intended to attract qualified students to the psychiatric specialty, including the provision of generous scholarship money in return for the commitment of the prospective student to practice that specialty in the province of Alberta for a specified period of time after graduation.

ii. Police and crisis teams

In his evidence Dr. White described a new initiative to make it easier for families who have loved ones with mental health issues to access the mental health system. Funded by federal dollars for two years, it has provided for the creation of police and crisis teams ("PACT"). Each team consists of a mental health therapist and an Edmonton Police Service officer trained in mental health issues. There are three such teams within the city and they are available on a 24-hour-a-day basis. According to Dr. White, the purpose of these teams is:

> …to facilitate access for persons with mental health problems into care. But also a number of patients because of their illness can get involved in petty crime, so

> the idea is to steer these patients, not through the court system but into the mental health system. …and it's had an 85% success rate in the first year.

Unfortunately, the new PACT teams are not available to the residents of suburban regions around the capital. Instead families are left to the more cumbersome options available under existing legislation and are constrained by the more limited resources available in suburban areas: *e.g.* - calling a crisis line, making a court application or attempting to get an admission certificate from a physician.

Before an admission certificate can be issued, the issuing physician must have seen the patient and been satisfied that the narrow preconditions set out in section 2 of the *Mental Health Act* ("the *MHA*") are present. That procedure is made more difficult by the inability of a family member or friend to legally force a patient to submit to an examination. When that consent is withheld, as it often is, the only recourse for the family member or friend is either to make a provincial court application, complicated by forms and court availability, or to ask a police officer to exercise the limited power granted under s.12 of the *MHA* to apprehend without warrant and deliver the person to an appropriate facility for examination. Not surprisingly, this is usually both a distasteful and daunting choice for the people involved. In the words of Dr. White, "These are very difficult situations and we see these situations on a daily basis."

In the alternative, as I understand the evidence, PACT teams have become very adept at persuading prospective patients to voluntarily enter the mental health system. In cases where the situation is more serious and consent is not forthcoming, a peace officer trained in mental health issues is already there to exercise his or her s.12 power.

According to Dr. White there is an initiative to expand the PACT program to nearby suburban areas, but there is a concern that the volume of calls in each area would not justify the creation of local teams. An intermediate solution would be to create part-time PACT teams with appropriately trained police members and mental health therapists always on call: a smaller, less complicated version of the present ERT team system. Another option would be to ensure that all RCMP officers in the suburban areas receive mental health training, perhaps not the extensive training PACT officers receive, but sufficient to make them useful and readily available to mental health therapists who might want to visit a patient in response to a call to the Edmonton crisis line. Aside from the obvious public benefit from the availability of such a resource, there is a wider public interest in ensuring that every police officer is familiar with and sensitive to mental health issues. That view is shared by Dr. White, who observed at the inquiry,

> …because of the trend in what we're seeing in mental health in the community I think it not unreasonable that obviously each officer would have experience in mental health like every family physician has increasing experience in mental health and it applies right throughout the system because the mental health issues are increasing day by day.

Even though the Capital Health Region does not, given the manpower shortage already referred to, have the resources to provide generalized mental health training to all RCMP officers, it could, according to Dr. White, provide some training, even with its present roster, "if the money was there". Such training would probably consist of monthly lectures on mental health issues to rotating groups of police officers.

Despite the rather supercilious reply to the recommendations contained in the report of the Commission for Public Complaints Against the RCMP, which Mr. Davison filed as Tab B in support of his final submissions, I am satisfied that the present training of RCMP recruits could also be improved by the provision of training arranged with and provided by mental health professionals, neither of which appears to be substantially present in the present training. In that

way even new recruits might, in dealing with those who come in conflict with the law, more easily understand the challenges presented by those who are suffering from various forms of mental illness.

IT IS THEREFORE RESPECTFULLY RECOMMENDED that the Government of Alberta promote, in consultation with Health Canada, the creation of part-time PACT teams in the suburban areas surrounding the City of Edmonton, which promotion should include, if necessary, the financial support of the province. It is further respectfully recommended that funding be provided for ongoing monthly mental health education for all RCMP officers stationed in the suburban Edmonton area. It is finally respectfully recommended that the Government of Alberta, in consultation with RCMP management, encourage the Government of Canada to include a greater mental health component, provided by mental health professionals, in the training of new recruits to the force.

d. Legislation

i. Involuntary admission

Nowhere is the struggle to reconcile a patient's rights with the rights of society-at-large more apparent than in our mental health legislation. When asked if he was "aware as to any intervention which had taken place in regard to Martin Ostopovich's obvious mental problems", Cst. Paul White, an ERT team sniper with more than 25 years experience in the RCMP, expressed his exasperation in these words:

> All that I can say is that we deal with schizophrenic people on a daily basis and we have no idea what to do with them. The system will not deal with them. If they are a threat to themselves or others or suicidal, we take them to a doctor. If they change their mind and tell the doctor they are not suicidal, they're released out that door and it's a situation … I have no idea how to deal with it. Unless they're committing a criminal act there's just … and of course they're mentally ill so that becomes a problem. They usually send them off; they get them re-medicated and they're released again. It's just the … I have no answer for that. I don't think society has an answer for that either.
>
> I just know what we can do legally and what we can't do. And an example is I had a fellow who was schizophrenic and who was going to hitchhike to B.C. when it was thirty below at night, 10 o'clock at night, from the home where they stay. And he had a jean jacket on and so I simply asked him, "Are you going to hitchhike?" And he said, "Yes." I arrested him under the *Mental Health Act* for his own safety (and) took him to the hospital. The doctor said, "He's not suicidal; I'm going to release him." And so I said to the doctor, "I need your name because he's going to be found frozen stiff somewhere between here and Hinton and I need your name to say that at least I took him to you." And then he said, "Oh, somebody will take him to Ponoka." So they took him to Ponoka. But I know for a fact that he would have been … you know, make sure the medicines are up and then he'd be out that door. I know that's the way it works. So you're kind of powerless to do anything really. I don't know what the answer is. There's a lot of schizophrenic victims out there.

Wendy Ostopovich, in her evidence, also expressed her frustrations at the difficulties even family members have trying to get treatment for someone with a mental illness. One of the problems facing *both* Cst. White and Mrs. Ostopovich, and the doctors to whom patients are brought, is section 2 of our *Mental Health Act*. That section prevents the involuntary admission and treatment of those with mental disorders unless, among other less contentious pre-conditions, the

patient is “in a condition presenting or ***likely to present*** a danger to the person or others” (emphasis mine): *MHA*, s. 2(b). That section is routinely interpreted by the medical profession as requiring the discharge of any patient involuntarily admitted pursuant to its provisions *as soon as the pre-conditions justifying involuntary admission disappear*.

Mr. Ostopovich’s situation is a case in point. He ended up in the Royal Alexandra Hospital psychiatric unit on May 24th, 2002 as the result of a warrant issued pursuant to s. 10 of the *Mental Health Act*. That warrant was issued in part because he was making threats against RCMP officers. He was assigned to the care of Dr. Sandy Frank, a specialist in general adult psychiatry who gave evidence at the inquiry. She found Mr. Ostopovich to be aggressive, intimidating and a man who would not follow the rules on the unit in which he was placed: in short, a difficult patient. He was diagnosed as paranoid delusional. Despite that and despite the fact that the admission certificate permitted his detention for up to 30 days, it was cancelled on June 7th and, to the surprise of his wife, he was permitted to discharge himself “against medical advice”.

What that meant in his case was that Dr. Frank, although she would have preferred to continue treating him, felt compelled by the legislation to cancel the certificate which put him in her care. She put it in these words,

> I was concerned about the level of risk that Martin Ostopovich, his illness, presented and the difficulty I have clinically was in determining how imminent the danger was in order to meet, to continue to meet, the criteria of certification under the *Mental Health Act*. (questions) No, actually, the assessment process proceeds throughout the stay and under the *Mental Health Act* the psychiatrist is required to cancel the certificate when the patient no longer meets the criteria for certification. It is one of the safeguards under the *Act* respecting people, individual’s rights and freedoms.

Although the *Mental Health Act* does not itself define the phrase “likely to present” as it is used in section 2(b), the review panels set up as a safeguard to potential abuse of the powers it confers have apparently done so. According to Dr. Frank:

> Based on my experience in review panels that danger is understood to be imminent. It’s not a theoretical danger. ..... And in my mind that time frame is up to two weeks or a month. That’s my understanding and in consultation with colleagues as well.

The so-called “discharge against medical advice”, then, is in reality an acknowledgment by the treating psychiatrist that the patient needs further treatment and, not surprisingly, is used to absolve the physician of responsibility for the potential consequences of an early discharge. Dr. Frank explained it this way:

> …and at that point Martin was allowed to discharge himself against medical advice, meaning that when a patient discharges himself against medical advice, they are taking the responsibility for the potential consequences of the decision. I also, in an attempt to reduce the risk, I did provide him with medications and a prescription for two weeks with one refill.

The obvious conundrum facing the psychiatrist is the knowledge that further treatment is necessary and the inability to provide it without the consent of the patient. In Mr. Ostopovich’s case Dr. Frank pointed out her concerns about his early discharge:

> The medical advice is to stay and receive further treatment. Certainly I

> recognized that his symptoms were not gone. I felt that the (medicine) had calmed them or decreased to some degree but they were still very much present.

Considering the potential risk to society, psychiatrists should not be put in such a difficult position. The *Mental Health Act* itself contains adequate review procedures to safeguard a patient's rights. In many, if not most, of these cases it is not simply a question of the patient's right to refuse treatment and therefore accept the personal consequences of that decision. The refusal of treatment has potential implications for society at large in that an untreated patient may become a danger to others yet again. If the mental illness has reached a stage serious enough to justify involuntary committal in the first place, those in charge of treatment should be given sufficient time to at least stabilize that condition. An appropriate compromise would be to allow the treating psychiatrist sufficient time after admission to administer meaningful treatment so that the danger of a relapse on discharge is minimized while still providing the patient with the right to a review of the doctor's decision to refuse discharge after the pre-conditions justifying involuntary admission have disappeared.

IT IS THEREFORE RESPECTFULLY RECOMMENDED that the *Mental Health Act* be amended to permit a psychiatrist treating a patient pursuant to an admission certificate to continue such treatment for up to 30 days, whether or not the criteria justifying the initial admission have disappeared, if the treating psychiatrist, with the supporting opinion of another psychiatrist, feels that the extended treatment is necessary to ensure a stable and safe discharge. The present provisions regarding the patient's right to a review hearing should also be amended to include a right to the review of any decision for extended treatment.

ii. Community treatment orders

You will recall that Dr. Frank, when she did discharge Mr. Ostopovich "against medical advice", attempted to reduce the risk by providing him with medications and prescriptions. Over time he stopped taking those medications, highlighting another problem in the treatment of the mentally ill: those who are non-compliant with treatment. Dr. White described the usual situation in his testimony:

> ..... There's a minority of patients within the system who are seriously mentally ill and who have a long history of non-compliance with treatment. They will come into hospital, be certified or come in voluntarily, leave hospital. (They) probably have limited insight into the fact that they're sick and they stop taking their medication. Back into hospital, treated, stabilized. Back out; back in again. The revolving door syndrome.

Two provinces, Ontario and Saskatchewan, have taken steps to deal with this problem by making provision for "community treatment orders" in their mental health legislation. This is a procedure whereby patients with a history of non-compliance must continue treatment in the community regardless of their personal wishes.

Forcing someone to accept treatment is of course controversial. Dr. White put it in these terms:

> A hot debate about it is going on as we speak. We talked about it at the Canadian Psychiatric Association meeting two weeks ago in Vancouver. And it's a fairly hot topic and there are people out there who object to it and have concerns about it. I think 99% of psychiatrists who see these patients coming into hospital all the time would certainly welcome some kind of community treatment order where we can treat patients in the community…

Considering the fact that the withholding of consent in these cases is often due to a lack of

insight by the patient into his or her condition and therefore in one sense not fully informed, considering the potential risk to the patient and to others when consent is withheld and considering that adequate safeguards can be built into the enabling legislation, I believe the time has come for the implementation of legislation allowing for community treatment orders. Had such legislation been in place in the years leading up to this incident, the tragedy it spawned might well have been avoided.

The approach in the two provinces where the legislation does exist is not the same. Ontario *does* require the consent of the patient, or a "substitute decision-maker" as defined by the *Act*, to the community treatment plan before the order can be made. Obtaining that consent is made somewhat easier by listing in the *Health Care Consent Act* and its Regulations a number of categories of health care professionals who may act as evaluators in determining whether the patient is capable of giving consent. If he or she is incapable, s. 20 of the same *Act* lists a number of "substitute decision makers", including the person's spouse, who might give the consent for him or her. The general approach of the legislation is to encourage the patient to participate in treatment in the community as an alternative to involuntary admission.

In that regard it should also be noted that the criteria for involuntary admission in Ontario are considerably wider than in s. 2 of our *Mental Health Act*. For a first involuntary admission, the attending physician need only be satisfied that the "patient is suffering from mental disorder of a nature or quality that likely will result in, (i) serious bodily harm to the patient, (ii) serious bodily harm to another person, or (iii) serious physical impairment of the patient, unless the patient remains in the custody of a psychiatric facility…": *Mental Health Act*, R.S.O. 1990, c. M.7 as amended, s. 20 (5).

For those who have been treated before, i.e. - the ones who qualify for community treatment plans, the grounds for involuntary admission are even broader. They include a finding that the patient "given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical or physical deterioration or serious physical impairment": *ibid.*, s. 20(1.1) (d).

The Saskatchewan legislation allows a community treatment order without any consent from the patient if he or she meets the other pre-conditions and "as a result of the mental disorder, the person is unable to fully understand and to make an informed decision regarding his or her need for treatment or care and supervision": *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1 as amended, s. 24.3(1) (a) (v).

Both laws contain numerous safeguards from abuse and preserve the patient's right to a review of a community treatment order. One difficulty is deciding at what stage of his or her illness a patient first might become subject to a community treatment order. In Ontario the person must have, during the previous three-year period, "…been a patient in a psychiatric facility on two or more separate occasions or for a cumulative period of 30 days or more during that three-year period,…": *Mental Health Act*, *supra.*, s. 33.1(4). In Saskatchewan the person must have been detained, during the immediately preceding two year period, in an in-patient facility for a total of 60 days or longer or been detained in an in-patient facility on three or more separate occasions: *Mental Health Services Act*, *supra*, s. 24.3(1)(a)(ii)(A)(B). The timing of such an order in Alberta of course should attempt to respond to conditions in this province and is ultimately a question for the legislature to settle.

IT IS THEREFORE RESPECTFULLY RECOMMENDED that the province, in consultation with the affected medical health professionals, draft and incorporate into the *Mental Health Act* of Alberta provisions permitting the making of community treatment orders in circumstances to be spelled out in the legislation. For your assistance in determining whether to implement this

recommendation, I attach copies of the relevant legislation in the provinces of Ontario and Saskatchewan.

iii. Communication

One of the striking aspects of the evidence presented at the inquiry was the lack of communication between the mental health system and family physicians. Part of this is a problem of how records are kept in individual doctor's offices and thus beyond anything I can usefully recommend to you. I do note, however, that although Dr. Moss, Mr. Ostopovich's family physician, was sent a copy of his discharge summary from the Royal Alexandra Hospital, it was not brought to his attention by his staff for quite some time. That might have been avoided if the Royal Alexandra Hospital had been required to follow up with him.

The concern here is the perceived inability of mental health practitioners to contact family physicians or to forward documentation to them without the patient's consent. When questioned about whether she followed up with Dr. Moss after Martin Ostopovich's discharge "against medical advice", Dr. Frank noted that

> .... No, and in fact the truth is that if a patient objects to notifying the family doctor through the discharge summary, I do not request a copy of the summary to the family doctor. I do have to respect a patient's rights to confidentiality.

When asked if she follows up in cases where there is no request by the patient not to disclose, the doctor noted that a discharge against medical advice is an indication by the patient that he or she is assuming responsibility for his or her own care and the physician no longer has any professional or ethical obligation to that patient.

That is true, of course, but it does not address the problem of trying, so far as possible, to encourage a patient to continue treatment. Community treatment orders, if they become law, will respond to at least a part of that problem, but even at an earlier stage there should be some attempt to foster co-operation between health care professionals in an effort to monitor potential problems. I see nothing affecting in any substantial way a patient's right to privacy by requiring one medical doctor to notify another of an assessment and recommended course of treatment for the latter's patient, especially since both physicians have the same obligation of confidentiality to that patient. The patient still has the right not to continue treatment and to refuse to attend his doctor's office, but it would at least give family members, friends and the public-at-large some comfort to know that the physician most likely to be in regular contact with that person has a complete knowledge of his or her mental history and may thus be better able to give cogent advice on what steps to take when problems arise.

IT IS THEREFORE RESPECTFULLY RECOMMENDED that the *Mental Health Act* be amended to require in-patient facilities to provide the family physician, if known, with a copy of the patient's discharge summary including any recommended treatment, within a stated period of time after discharge from an involuntary admission and to follow that up within a further period of time with an inquiry as to whether the patient has contacted his or her physician and to inform the patient upon discharge that they are required to do so.

4. The Media

One of the troubling aspects of the incident which occurred on February 28th, 2004 was the role the media unknowingly and unwittingly played in provoking the confrontation which led to the deaths of Corporal Galloway and Martin Ostopovich. One of the primary reasons the negotiators decided to inform Ostopovich of the presence of the ERT team was their fear that he would hear it being reported on the 6 o'clock news. It was never made clear at the inquiry why no one

thought to ask the media to leave that fact out of their reports. That may have simply been an oversight by police. It may also have been the consequence of a fear that they would be accused of trying to censor media reporting if they asked.

If it was the latter, that is an issue which should be addressed. I invited the media to provide a spokesperson at the inquiry so that those problems could be explored but they declined, citing an inability to find one person who could adequately speak for all the different media players involved. Accordingly, given the lack of evidence, I cannot make any useful recommendations in that regard.

However, I do observe that it would be beneficial to all the parties involved to open a dialogue among themselves in an effort to achieve a comfort level when these issues arise. In that way the police may come to better understand the important role the media have to play in our society and the strictures under which street reporters work and media management, in turn, may come to understand that sometimes restraint in their coverage may well be in the public interest. That approach does not mean the public will be deprived of important information, but only recognizes that the public's right to know does not *in every case* mean the right to know every detail right now.

DATED November 3rd, 2006

at Stony Plain, Alberta.

Original signed by

P. AYOTTE
A Judge of the Provincial Court of Alberta