BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

VERDICT AT INQUEST

File No.: 2008:0364:0669

An Inquest was held at the Coroner's Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates May 18-20, 2010

before Jeffrey M. Dolan, Presiding Coroner,

into the death of STITT, David James (Last Name, First Name, Middle Name) 46 (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: June 19, 2008 @ 1440 hours

Place of Death: Peace Arch Hospital (Location) White Rock, British Columbia (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Cardiorespiratory Arrest

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Agitated Confusional State (Excited Delirium) and Restraint

DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c) Acute and Chronic Cocaine Use

(2) Other Significant Conditions Contributing to Death:

Classification of Death: ☒ Accidental ☐ Homicide ☐ Natural ☐ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 20th day of May AD, 2010.

J.M. DOLAN
Presiding Coroner's Printed Name

Presiding Coroner's Signature

Stitt	David James
SURNAME	GIVEN NAMES

Parties Involved in the Inquest:

Presiding Coroner: Mr. Jeffrey Dolan

Coroner Counsel: Mr. Rodrick MacKenzie

Court Reporting/Recording Agency: Ms. Vivian Kariya/Verbatim Words West Ltd.

Participant/Counsel: Royal Canadian Mounted Police, Attorney General of Canada/Mr. David Kwan

The Sheriff took charge of the jury and recorded seven exhibits. Twenty-one witnesses were duly sworn in and testified.

Presiding Coroner's Comments:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. The summary is provided to assist the reader to more fully understand the verdict and recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

Events of June 17-19, 2008:

A Surrey neighbour of Mr. Stitt testified that he heard a disturbance coming from the Stitt property at 2348 hours on the night of June 17th, 2008. The witness stated that he heard what he believed to be a dog in distress and a male who was angrily making religious statements aloud. The agitated male was later confirmed to be David James Stitt.

The neighbour testified that he called 911 to report that the male (Mr. Stitt) had broken a window and was spraying water into the residence. He then observed Mr. Stitt walking into traffic on Crescent Road.

The first Surrey RCMP constable testified that she arrived at the Stitt property just prior to midnight. She observed Mr. Stitt striking at something with a stick and was concerned it may be another person. The officer testified that Mr. Stitt appeared sweaty and his clothes were dirty as though he had just been in a fight. Mr. Stitt dropped the stick on her command and their verbal communication quickly escalated to a physical altercation.

Unable to physically restrain Mr. Stitt, the officer testified that she used her pepper spray to no effect. Using her collapsible baton the officer struck Mr. Stitt several times on his thighs, also with little effect. The officer testified that she intentionally avoided striking Mr. Stitt's head and torso, knowing that strikes to these vital areas could be lethal. Mr. Stitt's neighbour and a passing motorist assisted the officer to restrain Mr. Stitt until three backup officers arrived at 0004 hrs.

The jury heard from the police and civilian witnesses that Mr. Stitt was observed to be gurgling and spitting once he was handcuffed on the ground in a prone position. He was noticeably limp and unresponsive when two male officers attempted to lift him to his feet. The officers testified that they carried Mr. Stitt to the front of a nearby police vehicle where they assessed his vital signs. Finding no pulse, one of the officers radioed dispatch to send an ambulance for a male in cardiac arrest.

The two male officers testified that they initiated cardiopulmonary resuscitation (CPR) at 0012 hrs, but at first were not able to locate an artificial respiration mask. An RCMP supervisor later informed the jury that every police vehicle is equipped with a first aid kit containing an air mask. Officers are required to confirm the vehicle first aid kit is complete at the start of every shift.

Two Surrey Fire Department witnesses testified that they took over CPR upon their arrival at 0015 hrs. The firefighters applied the automatic external defibrillator (AED) pads to the chest of Mr. Stitt and found no shockable rhythm. Chest compressions and artificial respirations were continued and again no shock was advised.

The jury heard that Surrey firefighter first aid training is updated every three years and includes the use of the AED. The second firefighter testified the administration of CPR was not compromised by Mr. Stitt being handcuffed behind his back.

Neither of the two Surrey Fire Department witnesses had any knowledge of the state of excited delirium or their department's current position on excited delirium training.

The jury heard that BC Ambulance Service basic life support (BLS) paramedics were the first to arrive at the scene at 0017 hrs followed by the advanced life support (ALS) unit. The BLS paramedic testified that Mr. Stitt had no vital signs and was not responsive to stimuli. The ALS paramedic testified that they were able to regain a pulse at 0025 hrs with the administration of epinephrine, atropine and sodium bicarbonate. Mr. Stitt was transported to the Peace Arch Hospital Emergency Department at 0039 hrs.

The emergency room physician who assessed Mr. Stitt testified that he was not breathing and was neurologically unresponsive with a very low blood pressure upon arrival. His recorded body temperature was elevated at 39°C and the admission urine screen was positive for marijuana and cocaine.

Mr. Stitt was transported to the intensive care unit with a very poor prognosis. He remained unresponsive and died at 1440 hours June 19th, 2008.

The senior Surrey RCMP officer on duty on the night of June 17, 2008 testified that she

did not feel there was an undue delay of the backup provided to Cst. Stewart. The sergeant testified that, with the exception of training situations, Surrey RCMP assigns one officer per patrol vehicle.

The jury heard that limited excited delirium training is provided to cadets at the RCMP training facility in Regina Saskatchewan. Officers posted in British Columbia receive further education on excited delirium during regularly scheduled training at the provincial facility.

The senior RCMP witness testified that she did not believe emergency responders could have done anything on June 18th, 2008 to prevent the death of Mr. Stitt.

Mr. Stitt's family members testified that he had no history of violence or aggression and was a not religious man, which made his behaviour and utterances on the night of June 17, 2008 out of character. Mr. Stitt was known consume to alcohol and occasionally use marijuana. Mr. Stitt was not known to have used cocaine for several years.

Post-Mortem and Toxicology Results:

The RCMP forensic toxicology specialist testified that the blood drawn from Mr. Stitt on June 18, 2008 was found to contain alcohol and metabolites of cocaine and marijuana.

The cocaine metabolites found in Mr. Stitt's blood were consistent with a multi-dose binge pattern of use prior to his collapse.

The forensic pathologist who conducted the autopsy of Mr. Stitt testified that the cause of death was cardiorespiratory arrest due to agitated confusional state (excited delirium) and restraint due to acute and chronic cocaine use. The autopsy findings included external surface abrasions to Mr. Stitt's extremities and soft tissue bruises of his neck, chest, back and right leg.

The pathologist testified that Mr. Stitt's behavior on June 17th and the presence of cocaine breakdown products in the antemortem blood were typical of excited delirium or an agitated confusional state secondary to cocaine use. He explained that the agitated confusional state appears to be a consequence of decreasing levels of cocaine in the brain following a binge of several hours or days. The dropping levels of cocaine in the brain negatively impact the dopamine neurotransmitters and result in confusion, paranoia, aggression and an increase in body temperature. The stimulant effect of cocaine on the heart results in an increase in blood pressure, heart rate and catecholamine (epinephrine) levels. This can result in a heart muscle that is highly sensitive to arrhythmias. Sudden cardiac stoppage could result from a further surge of catecholamine associated with the fight or flight response to an altercation with police.

Police Use of Force:

An independent police use of force expert provided the jury with an overview of the Incident Management and Intervention Model (IMIM) used by all members of the RCMP. The model is a visual aid that assists with the explanation of the intervention methods chosen by an officer to manage an incident. A police officer must form his or her risk assessment by taking into account the totality of the situation including the peace officer's assessment of situational factors and a subject's behaviour. Occurrences can be resolved through dialogue, but occasionally intervention by use of force may be necessary. Lethal force is used only when preventing death or grievous bodily harm to peace officers and the public and when a lesser means is not appropriate.

The IMIM demonstrates the options available to police beginning with officer presence and communication, which remain constant throughout the model. An officer's decision to apply an intervention method is based on his or her perception of the situational factors; whether an individual is cooperative, passively resistant, actively resistant, assaultive or has the potential to cause grievous bodily harm or death. Officer options progress from presence and communication to soft control, physical control and hard control using intermediate weapons (pepper spray, baton, Taser) and ultimately lethal force. An officer also has the option to reposition him or herself out of harm's way at any time.

The expert testified that it is an officer's duty to respond to an occurrence in a manner that preserves the safety of the police and the public.

Police Investigation:

A sergeant from the Integrated Homicide Investigation Team (IHIT) testified that the team is responsible for investigating homicides, police involved shootings and in-custody deaths that occur within the British Columbia Lower Mainland areas policed by the RCMP, Abbotsford, New Westminster and Port Moody police departments.

The IHIT sergeant testified that his unit investigated the arrest of Mr. Stitt to determine if the force applied by officers was in accordance with section 25 of the *Criminal Code of Canada*. Section 25 allows a police officer to use as much force as deemed necessary for the enforcement and administration of the law. The onus is on the police officer to show that, under the circumstances, the level of intervention used was justified and appropriate to the situation.

The sergeant testified that IHIT investigators concluded that the level of force used by the Surrey RCMP officers during their arrest Mr. Stitt on June 18, 2008 was not excessive. No criminal charges were laid.

The sergeant testified that a search of Mr. Stitt's residence identified white powder on a plate which appeared to be cocaine. The substance was not submitted to the police lab for analysis since there was no possibility of criminal charges against Mr. Stitt. The finding did however prompt police to analyze his blood for the presence of cocaine.

Excited Delirium and Sudden In-Custody Death:

The jury heard from an emergency medicine physician who has conducted extensive research on excited delirium and sudden in-custody death. The physician testified that delirium is a state of altered level of consciousness with impairment of cognition and perception. Behaviour can range from obtunded to extreme agitation. An excited delirium state can be generated by psychiatric illness, drug intoxication or a combination of both.

The physician testified that emergency personnel should be conscious of information that may suggest an individual is in a state of excited delirium:

- Known or suspected psychiatric illness
- Known or suspected drug or alcohol intoxication
- Multiple calls to the same location or for the same individual
- Agitated, bizarre or destructive behavior

The visible signs that a state of excited delirium exists include:

- Bizarre, irrational behaviour, constant or near constant physical activity
- Constant yelling/screaming/"keening"
- Aggression toward inanimate objects
- Glass attraction
- Inappropriate attire; often naked or semi clothed

The jury heard that an individual in an excited delirium state does not respond as expected to police or medical staff. They may have insensitivity to pain, physical restraints, pepper spray or a Taser in drive-stun mode. The individual may have very hot skin and may or may not sweat profusely.

Individuals in a state of excited delirium will have apparent superhuman strength. It usually requires multiple police officers to restrain the individual who may continue to struggle despite being handcuffed or mechanically restrained.

The physician testified that police officers are not trained to make a diagnosis of excited delirium. Paramedics also do not make diagnoses; however, treatment can be initiated without a clear diagnosis of excited delirium. A diagnosis must be conducted by a physician and requires an accurate medical history, physical examination and investigative testing.

Many people with excited delirium progress to cardiac arrest. In cases of in-custody death, the collapse occurs once the individual is successfully restrained. Cardiopulmonary collapse usually occurs within 5 to 15 minutes of the individual becoming quiet and resuscitation is rarely successful. Recorded deaths have occurred at arrest scenes, in police cars, cells, ambulances and hospitals.

The physician testified that some of the deaths can be prevented with early directed interventions. Where possible, pharmacological restraints such as benzodiazepines, ketamine or other major tranquilizers should be implemented by paramedics at the scene.

Emergency Responder Training:

The physician explained to the jury that police agencies can train police officers to recognize fact patterns that point to excited delirium. Officers do not need to diagnose why a subject is delirious. They should attempt to de-escalate the situation and prepare to gain control of the person. Physical control of the patient is required for diagnosis and treatment.

Police and ambulance service personnel can coordinate their responses and develop protocols for sedation by advanced life support paramedics. It must also be understood that sedation does not a guarantee the safety of the affected person or the first responders.

The jury heard that medical experts have not defined a clear pathology for in-custody deaths following excited delirium. Medical professionals continue to strive to understand excited delirium and sudden in-custody death. Emerging treatment protocols require the cooperation of the police, paramedics, physicians and medical examiners.

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Pursuant to Section 38 of the *Coroners Act*, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

Jury Recommendations:

Following a review of the evidence presented the jury classified the death of David James Stitt as accidental made no recommendations.