Office of the Chief Coroner
Bureau du coroner en chef

Verdict of Inquest Jury
Verdict de l'enquête

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

We the undersigned / Nous soussignés,

_____ of / de _____

_____ of / de _____

_____ of / de _____

_____ of / de _____

_____ of / de _____

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de:

Surname / Nom de famille	Given Names / Prénoms
MacDougall	Quinn Emerson

aged / à l'âge de 19 held at / tenue à 25 Morton Shulman Ave Toronto (Virtually) , Ontario

from the / du 28 February to the / au 11 March 20 22

By / Par Dr. / Dr David Eden Presiding Officer for Ontario / président pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit :

Name of Deceased / Nom du défunt
Quinn Emerson MacDOUGALL

Date and Time of Death / Date et heure du décès
4:23 pm on April 3, 2018

Place of Death / Lieu du décès
Hamilton General Hospital, 237 Barton Street East, Hamilton, Ontario

Cause of Death / Cause du décès
Gunshot wound of the torso (right chest)

By what means / Circonstances du décès
Homicide

Original confirmed by: Foreperson / Original confirmé par: Président du jury

_____

_____

_____
Original confirmed by jurors / Original confirmé par les jurés

The verdict was received on the / Ce verdict a été reçu le 11 (Day / Jour) day of / March (Month / Mois) 20 22

Presiding Officer's Name (Please print) / Nom du président (en lettres moulées)	Date Signed (yyyy/mm/dd) / Date de la signature (aaaa/mm/dd)
Dr. David Eden	2022/03/11

_____
Presiding Officer's Signature / Signature du président

We, the jury, wish to make the following recommendations: (see page 2)
Nous, membres du jury, formulons les recommandations suivantes : (voir page 2)

Office of the
Chief Coroner

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coroner en chef

Verdict of Inquest Jury
Verdict de l'enquête

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Inquest into the death of:
L'enquête sur le décès de:

Quinn MacDougall

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

Directed to the Ministry of the Solicitor General (SolGen)

1. Review the current Use of Force Model (2004) and related regulations, and consider de-emphasizing use of the term "force" and employing alternative terminology.

2. Review the current Use of Force Model (2004) and related regulations, and consider incorporating the concept of de-escalation expressly (both in terminology and visual representation) into the Model as a response option and/or goal.

3. Explore and research the availability and efficacy of additional less-lethal use of force options for officers.

4. For conductive energy weapons consider high visibility markings (colour) to differentiate them from firearms.

Directed to the Hamilton Police Service (H.P.S.)

5. Explore the capability of the information management systems to "track" the deployment of alternative responses to assist a Person in Crisis (PIC) and the outcomes. To use any such collected information to assess the effectiveness of the deployed alternative responses, to identify the potential for the improvement of future responses and outcomes, and to support any request for additional resources.

6. Explore the capability of the information management systems to accurately capture the number of calls for service which are initially reported and dispatched as another type of call but are later assessed by the responding officers to be a call which has a significant Person in Crisis component.

7. Explore, with community mental health partners, the feasibility of extending the availability of Mobile Crisis Rapid Response Team (MCRRT) Units to 24 hours a day and of increasing the number of MCRRT Units available to respond to calls at all times.

Directed to all Police Services in Ontario

8. If none already exists, explore with community mental health partners, the feasibility of establishing and adequately resourcing joint mental health-police response teams to assist with Person in Crisis calls for service.

9. If a police service has a joint mental health-police team, give studied consideration to implementing a police policy that provides, once police officers attending a call identify a potential mental health concern and provided it is safe to do so, that the joint mental health-police team should be engaged.

10. Explore developing and providing all police officers with additional de-escalation training.

Directed to the Ontario Police College and the Ministry of the Solicitor General

11. Explore developing and providing all police recruits with additional de-escalation training.

12. Consider including conductive energy weapons training as part of the mandatory curriculum for police recruits at the Ontario Police College with a yearly re-certification.

13. Explore the possibility of developing and including crisis intervention training as part of the mandatory curriculum for police recruits at the Ontario Police College and the requirement that all officers re-qualify at a determined interval.

VERDICT EXPLANATION

Inquest into the Death of
Quinn MacDOUGALL

Dr. David Eden, Presiding Officer
February 28, March 1, 2, 7, 8, 10 and 11, 2022
Virtual Inquest

OPENING COMMENT

This verdict explanation is intended to give the reader a brief overview of the circumstances surrounding the death of Quinn MacDougall along with some context for the recommendations made by the jury. The synopsis of events and comments are based on the evidence presented and written to assist in understanding the jury's basis for the recommendations.

PARTICIPANTS

Inquest Counsel:
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Inquest Unit, Office of the Chief Coroner
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Recorder:
Massimo Pimentel
Inquest Unit, Office of the Chief Coroner
25 Morton Shulman Avenue
Toronto, ON M3M 0B1

Parties with Standing:	Represented by:
Family of Mr. MacDougall	Margaret Hoy, Counsel 207-6150 Valley Way Niagara Falls, ON L2E 1Y3
Ministry of the Solicitor General	Brian Whitehead, Counsel Ryan Ng, Student-at-Law Solicitor General, Legal Branch 501-655 Bay St. Toronto, ON M7A 0A8
Hamilton Officers Breitenbach and Lei	Gary Clewley, Counsel 360 Walmer Rd Toronto, ON M5R 2Y4
Hamilton Police Service	Marco Visentini, Counsel Hamilton Police Service 155 King St. W Hamilton, ON L8N 4C1

SUMMARY OF THE CIRCUMSTANCES OF THE DEATH

Quinn MacDougall, aged 19 years, died on April 3, 2018, following an interaction with Hamilton Police. An inquest into his death was mandatory under the *Coroners Act*. An Ontario inquest is a public hearing which takes place before a jury. The purpose of an inquest is for a jury to make findings of fact, and possibly preventive recommendations. No one is on trial, there are no allegations to be proven or disproven, and no findings of law or blame are made.

Mr. MacDougall lived with his mother and stepfather in a residential neighbourhood in Hamilton. Mr. MacDougall's father lived nearby, and the families were on good terms. He was employed seasonally, was in a relationship with a young woman whom he saw regularly and was making some plans for his future. He was previously medically healthy. He was known to use marijuana recreationally, and occasionally use self-prescribed, illicitly-obtained alprazolam ("Xanax") for anxiety. He had no significant history of mental disorder or of violence against others.

Very early on the morning of April 3, Mr. MacDougall sent messages to his girlfriend in which he expressed sadness and despair. She responded supportively. Later that same morning, Mr. MacDougall told his family that he had received anonymous death threats on his smartphone, using the SnapChat application. SnapChat is a social media app for which user identity is not confirmed, and on which messages are automatically deleted shortly after their arrival. His family believed the threat was serious enough that they counselled him to report it to police. There was no belief that the threats were specific or immediate. Anonymous death threats are common on social media, and most do not lead to physical danger. No other person saw the threats displayed on Quinn's smartphone. He contacted police via 9-1-1. His report was taken and classified as requiring a non-urgent police investigation. He was advised that an officer would attend at some point that day. This "call for service" was not classified as a report requiring immediate or urgent police attendance and was therefore assigned a lower response priority

Over the following hours, a friend visited. Mr. MacDougall told the friend and his family about his frustration and anxiety about the fact that police had not yet responded to take his report.

At 3:35 p.m., Mr. MacDougall made a call to 9-1-1 during which he reported that there was a person outside the residence with a gun, wielding it in a threatening way. This call was not heard by other occupants of the residence. The report was classified as requiring immediate police attendance. He was told that officers would respond immediately. Mr. MacDougall then went outside the residence. He asked a neighbour if he could use the neighbour's cellphone to call police. The neighbour agreed. Mr. MacDougall called 9-1-1 to provide additional information about the threatening individual then, despite a request from the 9-1-1 call-taker to stay on the line, terminated the call as police arrived.

Given the threat was reported as immediate and involving a firearm, this call for service was assigned an immediate response priority and all available police units were dispatched to attend. Ultimately five or more police units responded to this call.

When police officers arrived, Mr. MacDougall was unable to supply them with any further information about the call. He then identified to them a person in an SUV parked nearby as associated with the threat. Officers testified that they walked to the SUV. It was occupied by a plainclothes officer who had been performing an unrelated investigation but had also responded to the call given its priority. This officer did not match the suspect description that Mr. MacDougall had provided during the 9-1-1 calls. The officers walked back to Mr. MacDougall and reassured him that the SUV's occupant was not a danger to him. Initially calm, Mr. MacDougall became agitated, and displayed a knife. He approached the SUV holding the knife in a manner which, in the opinion of the officers, suggested he might injure or kill the occupant. The officer in the SUV rolled up his window, leaned away from it, and prepared to defend himself if necessary. Mr. MacDougall moved away from the SUV, with officers following him. The officers testified they followed him because they were aware that this was a public area, that there were

members of the public on the street, and that Mr. MacDougall might be a danger to others if they did not contain him. Officers instructed him to stop and to drop the knife. The less-lethal option of conducted energy weapon ("CEW", often known as "Taser") was tried three times unfortunately without effect. When Mr. MacDougall appeared to be advancing on a particular officer while holding the knife, it appeared to both officers and civilians that this officer would be stabbed Two other officers discharged their firearms. Mr. MacDougall walked a short distance, then collapsed. He was transferred to hospital via ambulance and pronounced dead after resuscitation efforts.

The case was referred to the coroner, and to the Special Investigations Unit, which investigates injuries or deaths due to police actions.

Autopsy showed multiple gunshot wounds, of which one to the chest was rapidly and irreversibly fatal. Toxicology showed the presence of THC, the active ingredient in marijuana. THC blood levels do not always correlate with clinical effects. The level seen in Mr. MacDougall may be associated with symptoms in a broad range from minimal to acute psychosis. Neither alprazolam nor other drugs were detected.

Expert psychiatric opinion
An independent expert in Forensic Psychiatry provided opinion evidence to the jury. He had reviewed the investigative file and was advised of the evidence heard during the inquest. He was of the opinion that Mr. MacDougall, previously well, had developed a mental disorder which included paranoia. The expert believed that Mr. MacDougall thought that others wished to cause him harm, and that he needed to defend himself, by lethal force if necessary. In such cases, the perceived threat might be from any person, including children or other bystanders. This syndrome can develop quietly. The first manifestation of mental illness may be an episode of agitation and paranoia, as occurred here. In the opinion of the expert, there was no opportunity for anyone (professionals, family or friends) to foresee and prevent the sudden change in his mental state on April 3.

Mental Health Alternative Responses
The jury also heard evidence that although the Hamilton Police Service does have Mobile Crisis Rapid Response Team (MCRRT) Units teaming officers with mental health workers, those teams were not initially dispatched for safety reasons given the nature of this priority call and that there was no identified mental health component. Further, the two in service MCRRT teams were already deployed on other calls at the time of this incident. This incident was only identified as a possible person in crisis call almost simultaneously with the knife being produced and there was no time or circumstances allowing for any alternative response.

Emergency response
The jury heard fact evidence from a trainer at the Ontario Police College, which provides initial training to officers and supports ongoing training. The witness explained that officers are taught the Ontario Use-of-Force model. This model provides overall guidance to police on dealing with a situation in which use of force may be required.

The model is not prescriptive, that is, it does not provide explicit instructions for every possible situation. Instead, it provides a structured, practical set of principles which officers can understand and rely upon in situations which involve considerable stress, evolve rapidly, and often last only a few seconds. While de-escalation is taught to officers as the preferred approach and is implicit in the Model, de-escalation is not explicitly listed (see Appendix 'B').

The witness also testified that a knife can inflict serious or fatal injuries on an officer. Service vest and clothing are not protective against an edged weapon. The length of the knife is not a significant factor. Relatively short knives, such as the one used in this incident, can and do inflict fatal wounds by opening major blood vessels which are close to the skin surface, for instance in the neck or thigh.

THE INQUEST

Dr. Karen Schiff, Regional Supervising Coroner for West Region, Hamilton Office, called a mandatory inquest into the death of Quinn MacDougall pursuant to section 10 of the *Coroners Act*.

The document outlining the scope of this inquest is attached to this document as Appendix 'A'.

The inquest took place during the Covid-19 pandemic and was conducted entirely as a virtual hearing, with remote participation by all. In keeping with the open court principle, the inquest was streamed live on YouTube.

The jury sat for seven days, heard evidence from 18 witnesses, reviewed 43 exhibits and deliberated for three hours in reaching a verdict.

VERDICT

Name of Deceased:	Quinn Emerson MacDougall
Date and Time of Death:	4:23 p.m. on April 3, 2018
Place of Death:	Hamilton General Hospital 237 Barton Street East, Hamilton, Ontario
Cause of Death:	Gunshot wound of the torso (right chest)
By What Means:	Homicide

Comment:
At an inquest, "By What means" is the jury's finding of fact. The jury's determination of "Homicide" means that the jury concluded that, on the balance of probabilities, Mr. MacDougall died of an injury which was non-accidentally inflicted by another person. The jury's finding of Homicide carries no criminal or other liability, and none should be inferred.

JURY RECOMMENDATIONS

Directed to the Ministry of the Solicitor General (SolGen)

1. Review the current Use of Force Model (2004) and related regulations, and consider de-emphasizing use of the term "force" and employing alternative terminology.

   Comment:
   The evidence was that revision of the Model is currently under consideration.

2. Review the current Use of Force Model (2004) and related regulations, and consider incorporating the concept of de-escalation expressly (both in terminology and visual representation) into the Model as a response option and/or goal.

   Comment on Recommendations #1 & 2:
   Witnesses agreed that de-escalation is an essential option any time that use of force is considered. It should be explicitly included in the use-of-force "Wheel" (see Appendix 'B').

3. Explore and research the availability and efficacy of additional less-lethal use of force options for officers.

   Comment:
   Two attempted deployments of conducted energy weapon ("CEW" or "Taser") were unsuccessful in containing Mr. MacDougall. Other, less lethal options carried by the officers, such as pepper spray or baton, were not a rational choice because they would not have contained the threat. For instance, a baton is not an adequate defence against a knife; and pepper spray not only does not preclude continued stabbing, but also may disable officers. The jury encouraged research into additional options which are less lethal than firearms.

4. For conductive energy weapons consider high visibility markings (colour) to differentiate them from firearms.

   Comment:
   The jury heard that high visibility markings would alert other officers that a CEW was deployed; and some agitated persons will de-escalate when aware that CEW may be used.

Directed to the Hamilton Police Service (H.P.S.)

5. Explore the capability of the information management systems to "track" the deployment of alternative responses to assist a Person in Crisis (PIC) and the outcomes. To use any such collected information to assess the effectiveness of the deployed alternative responses, to identify the potential for the improvement of future responses and outcomes, and to support any request for additional resources.

   Comment:
   Hamilton Police Service, like other large police services, is frequently the first responder to a mental health emergency. The training it provides to officers is detailed, consistent and supported by expert consensus. However, the Service does not track interventions and outcomes. This information, if collected, would provide a factual basis for improving the effectiveness and safety of police response.

6. Explore the capability of the information management systems to accurately capture the number of calls for service which are initially reported and dispatched as another type of call but are later assessed by the responding officers to be a call which has a significant Person in Crisis component.

Comment:
The officers responding to the 3:35 p.m. call ("person with firearm") were not aware of the report from the same address, hours earlier, of the SnapChat threat. This information, if available, may have been useful to them.

7. Explore, with community mental health partners, the feasibility of extending the availability of Mobile Crisis Rapid Response Team (MCRRT) Units to 24 hours a day and of increasing the number of MCRRT Units available to respond to calls at all times.

Comment*:*
MCRRTs provide a rapid and effective response to a mental health emergency. The team attend once the situation is stable. They cannot attend when there is an uncontained threat. This incident unfolded so rapidly that there was no time for MCRRT to be notified and, in any event, they would not have been able to attend until the situation was safe. However, the service would have been useful if de-escalation efforts had succeeded. The jury encouraged 24-hour availability of MCRRTs for similar incidents.

Directed to all Police Services in Ontario

8. If none already exists, explore with community mental health partners, the feasibility of establishing and adequately resourcing joint mental health-police response teams to assist with Person in Crisis calls for service.

Comment:
See comment at Recommendation #7. While Hamilton and many other police services provide joint mental health-police response teams, their availability is not consistent across Ontario, and it is often not available after hours. The jury encouraged increased access to such services across Ontario.

9. If a police service has a joint mental health-police team, give studied consideration to implementing a police policy that provides, once police officers attending a call identify a potential mental health concern and provided it is safe to do so, that the joint mental health-police team should be engaged.

Comment:
At the time a 9-1-1 call is made, it may not be clear that the underlying issue is a mental health crisis. In this case, the call was for a firearm threat, and it was not until the officers arrived that mental health became a consideration. This recommendation emphasizes that, as the situation unfolds, mental health services should be engaged where appropriate.

10. Explore developing and providing all police officers with additional de-escalation training.

    Comment:
    The jury heard evidence about de-escalation training provided to officers during initial training, mandatory ongoing training, and optional courses. They also heard that police are frequently the first responder to a mental health crisis. The jury advocated more training for police in this critical area.

Directed to the Ontario Police College and the Ministry of the Solicitor General

11. Explore developing and providing all police recruits with additional de-escalation training.

    Comment:
    See comment at Recommendation 10.

12. Consider including conductive energy weapons training as part of the mandatory curriculum for police recruits at the Ontario Police College with a yearly re-certification.

    Comment:
    CEW training is not currently mandatory for initial or mandatory ongoing training of police officers. Not all services deploy CEWs, and the extent of deployment varies (e.g. carried just by supervisors versus carried by all uniformed officers). The jury encouraged basic CEW training be routine for all officers.

13. Explore the possibility of developing and including crisis intervention training as part of the mandatory curriculum for police recruits at the Ontario Police College and the requirement that all officers re-qualify at a determined interval.

    Comment:
    In principle, both initial and mandatory ongoing training include crisis intervention techniques. In practice, the extent and nature of the training varies by police service. The jury encouraged a consistent and high standard of training in this area.

CLOSING COMMENT

In closing, I would like to again express my condolences to the family and friends of Quinn MacDougall for their profound loss.

I would like to thank the witnesses and parties to the inquest for their thoughtful participation, and to thank the inquest counsel, investigator, and constable for their hard work and expertise. I would also like to thank the members of the jury for their commitment to the inquest.

One purpose of an inquest is to make, where appropriate, recommendations to help prevent further deaths. Recommendations are sent to the named recipients for implementation and responses are expected within six months of receipt.

I hope that this verdict explanation helps interested parties understand the context for the jury's verdict and recommendations, with the goal of keeping Ontarians safer.

April 8, 2022

_____ _____

Dr. David S. Eden
Presiding Officer

Date

APPENDIX A

STATEMENT OF SCOPE

Inquest into the Death of Quinn MACDOUGALL

This inquest will look into the circumstances of the death of Quinn MacDougall and examine the events of his death to assist the jury in answering the five mandatory questions set out in s. 31(1) of the *Coroners Act.*

(a) who the deceased was
(b) how the deceased came to his or her death
(c) when the deceased came to his or her death
(d) where the deceased came to his or her death
(e) by what means the deceased came to his or her death

The following will be explored only to the extent relevant and material to the facts and circumstances of this death:

A. How police interact with a person who is:
    a. or appears to be, under the influence of a mental disorder; and,
    b. carrying an edged weapon which may represent a potential danger of serious or lethal injury to another person.

B. Insofar as it is relevant to the circumstances of the death of Mr. MacDougall and necessary in order to inform their findings and recommendations, the jury will hear the following fact evidence with respect to the police interactions described in (A):

    1. Law and procedures: the statutes, regulations and procedures which govern police officer response

    2. Science: current knowledge concerning effective management by police of persons similar to Mr. MacDougall

    3. Police training, skills, and documentation: the training provided to police officers who respond to this sort of incident, the skills expected, the documentation of interactions, and the use of that data to inform future policy

4. Mental disorder: the way in which a person with mental disorder may perceive events, which may differ substantially from the perception of others; and, options for de-escalating a crisis situation involving a person with a mental disorder

5. Substance use: the extent, if any, to which marijuana or any other substance contributed to the circumstances of the death.

The following are excluded from scope, except insofar as necessary to answer the five questions cited above, or otherwise ruled necessary by the Presiding Officer in order to inform jury recommendations:

1. Emergency response following the incident

2. The SIU investigation.

APPENDIX B

Ontario Use of Force Model