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
Ekamba	Marc Diza

aged / à l'âge de 22 held at / tenue à Toronto, Ontario

from the / du 16th of May to the / au 3rd of June 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
Marc Diza Ekamba

Date and Time of Death / Date et heure du décès
March 20th, 2015 at 10:53pm

Place of Death / Lieu du décès
3070 Queen Frederica Drive, Mississauga, ON

Cause of Death / Cause du décès
Multiple Gunshot Wounds

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 3rd (Day / Jour) day of / June (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	2022/06/03

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)

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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:

Marc Diza Ekamba

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

To all Ontario Police Services:

1. Improve knowledge and awareness for police communicators, call takers, and dispatchers of the signs of mental health crisis, and ensure that communicators are trained to ask questions directed at determining whether a call involves a mental health crisis.

2. Ensure that police officers responding to a mental health crisis are aware that police have responded previously to incidents involving the same parties, and facilitate access for responding officers to significant information regarding previous calls.

3. Ensure that all police officers who interact directly with the public are provided with the four-day mental health training currently provided to incoming police officers in their first year of service. Regular refresher training on mental health issues should be provided to all police officers who interact with the public.

4. Ensure that police officers can accurately identify their own Mental Health Act options and explain options available to complainants when a mental health issue is the basis for criminal conduct.

5. Continue implementation of the pilot enhanced de-escalation training developed by the Ontario Police College, and engage with OPC on its experience with the training and its potential implementation.

6. Ensure that persons with lived experience from peer-run organizations are directly involved in the development and delivery of both mental health crisis and de-escalation training.

7. Mandate that all Police Service officers receive annual implicit bias and cultural competency training to address stereotyping of Black people, and the existing research on anti-Black racism in policing.

8. Develop methods to evaluate the effectiveness of mental health, de-escalation and anti-racism training. The evaluation of the effectiveness of such training should include the participation of affected communities, including persons with lived experience from peer-run organizations.

9. Develop and implement a pilot project to explore the feasibility of dispatching crisis support workers to mental health service calls that do not require police involvement, similar to Peel Regional Police Mental Health Strategies.

10. Create emotionally supportive debrief sessions for police officers at the division or platoon level for those involved in critical incidents resulting in serious bodily harm or death, with regard for the Special Investigations Unit investigative process.

11. Ensure that witnesses or persons injured during an event that leads to a police-involved death are directed to trauma-informed supports.

12. Police Services and Police Services Boards shall establish standing or advisory committees on race and impartial policing and on mental health in order to meet with representatives of peer-run organizations and members of affected communities on an ongoing basis to discuss concerns and facilitate solutions.

13. Consult with the Ontario Anti-Racism Directorate to analyze race-based data collected by Police Services to measure and evaluate police service performance on use of force, take corrective action to address systemic

discrimination and provide clear and transparent information to the public on bias and discriminatory use of force.

14. Police Services and Police Services Boards shall establish permanent data collection and retention systems to record race, mental health issues, and other relevant factors on use of force incidents. The data should be standardized, disaggregated, tabulated and publicly reported. The data should include age, gender, perceived race, and officer perception of whether the individual has any mental health issues;

15. The results of the data collected on use of force incidents must be taught to all frontline Police officers.

16. Police Services and Police Services Boards shall consult with third-parties, including individuals from the Black community, Black advocacy community organizations, persons with lived experiences from peer-run organizations, and appropriate content experts, and:
a. Develop an objective methodology to measure and evaluate police service performance on use of force;
b. Take corrective action to address systemic discrimination; and
c. Provide clear and transparent information to the public on biased and discriminatory use of force

17. Training for new officers should be amended so that the question of the suspect's mental health be as prominent in their considerations as the criminal activity they have committed.

18. Training should be given to establish who should lead the call when dealing with a potentially violent incident or crisis.

All Ontario police services should seek and allocate funding and resources adequate to implement the above recommendations.

To the Peel Regional Police:

19. Re-evaluate the capacity of COAST and MCRRT teams to meet the growing need for these services in the Region of Peel.

Peel Regional Police should seek and allocate funding and resources adequate to implement the above recommendations.

To the Ministry of the Solicitor General:

20. The Ontario Use of Force model should be renamed to accurately capture the intent and purpose of the model, which is a guide to police engagement with the public rather than to suggest that force is inherent in police interactions.

21. The Ontario Use of Force model shall be redesigned to highlight and emphasize the importance of de-escalation at all points during police interactions.

22. The Ontario Police College shall ensure that persons with lived experience are engaged in the development and delivery of de-escalation training.

23. The Ontario Police College shall ensure that affected communities and persons with lived experience be directly engaged in the development and delivery of anti-bias training. OPC should ensure that community organizations who represent persons with lived experience are engaged in this work.

24. Revise the Use of Force Report form to require officers to document de-escalation techniques used.

To the Ministry of the Solicitor General and Peel Regional Police:

25. There must be special recognition of the unique challenges Black people who also have serious mental health issues face when they come into contact with police. This unique intersection of Blackness and lived

experience of mental health issues must be specifically addressed in any training on Use of Force, de-escalation, and police interaction with such persons.

The Ministry of the Solicitor General and Peel Regional Police should seek and allocate funding and resources adequate to implement the above recommendations.

To the Government of Ontario:

26. Commission a study to examine the creation and implementation of a province-wide, civilian-led crisis intervention system to respond to persons in crisis, including mental health crisis. This team should be staffed by trained mental health professionals, crisis intervention professionals, and persons with lived experience.

27. Improve public awareness of mental health issues to counteract stigma and discrimination against persons with mental health issues. Measures to improve public awareness should be developed in consultation with content experts and community organizations that represent persons with lived experience.

28. Improve public awareness of both policing and non-policing community-based crisis responses to mental health crisis. Efforts to improve public awareness of these options should be developed in consultation with content experts and community organizations that represent persons with lived experience.

29. Enhance information and supports available to families of persons experiencing mental health crisis with respect to community-based options to support their loved ones.

30. Improve public awareness and knowledge of community-based supports for persons experiencing mental health issues should target young people, and utilize channels of communication that are accessible and suitable for youth.

31. Rename crisis hotline services and create awareness campaigns to educate the public about their existence to make the public aware that these services are available before a person reaches the point of crisis.

The Government of Ontario should allocate funding and resources adequate to implement the above recommendations.

To Peel Housing Corporation:

32. Improve mental health awareness of housing support personnel, and in particular, concerning the recognition of mental health crisis.

33. Ensure that housing support personnel are aware of both the policing and community-based options available to respond to mental health crisis.

34. Ensure that housing support personnel communicate the options for both the policing and community-based options to address mental health crisis to affected tenants.

35. Review and improve training to housing support personnel on cultural competency, anti-Black racism, implicit bias, mental health and its intersectional nature.

Peel Housing Corporation should seek and allocate funding and resources adequate to implement the above recommendations.

VERDICT EXPLANATION

Inquest into the Death of
Marc Boekwa Diza EKAMBA

Dr. David Eden, Presiding Officer
May 16 – June 3, 2022
Virtual Inquest

OPENING COMMENT

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

PARTICIPANTS

Inquest Counsel:	Richard Garwood-Jones, Counsel Assistant Crown Attorney 400-45 Main St E Hamilton, ON L8N 2B7 Julian Roy, Counsel Makenzie Chan, Law Student Inquest Unit, Office of the Chief Coroner 25 Morton Shulman Avenue, Toronto, ON M3M 0B1
Inquest Investigator and Constable:	Det. Heather Readman Inquest Unit, Office of the Chief Coroner 25 Morton Shulman Avenue, Toronto, ON M3M 0B1
Recorder:	Massimo Pimentel Lynus D'Cruze Makenzie Chan Inquest Unit, Office of the Chief Coroner 25 Morton Shulman Avenue, Toronto, ON M3M 0B1

Parties with Standing[1]:	Represented by:
Family of Mr. Ekamba	Michael Davies, Counsel 352 Elgin Street Ottawa, ON K2P 1M8
Ministry of the Solicitor General	Deanna Exner, Counsel Ryan Ng, Articling Student Leanne Stevens, Law Student Solicitor General, Legal Branch 501-655 Bay St. Toronto, ON M7A 0A8
Peel Regional Police	Keith Geurts, Counsel Barry Stork, Counsel 2500-401 Bay St Toronto, ON M5H 2Y4
Empowerment Counsel	Anita Szigeti, Counsel Maya Toyob, Counsel Tanner Blomme, Counsel Suite 2001, 400 University Avenue Toronto, ON M5G 1S5
Black Action Defence Committee	Rick Frank, Counsel 101-171 John St Toronto, ON M5T 1X3 Demar Hewitt, Counsel Suite 2200, 181 University Ave Toronto, ON M5H 3M7

[1] Suzan Zreik, represented by counsel Michael Moon, applied for and was granted standing prior to the inquest. Ms. Zreik withdrew from standing prior to the first day of evidence, and did not take part in the inquest other than as a witness.

SUMMARY OF THE CIRCUMSTANCES OF THE DEATH

Marc Boekwa Diza Ekamba, aged 22 years, died on March 20, 2015, following an interaction with Peel Regional 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 the jury to hear evidence about the circumstances surrounding the death and 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.

Events Prior to Death

Mr. Ekamba lived with his mother and his younger sister, then 16 years old, in a townhouse in a residential neighbourhood of Peel. His family had moved from the Democratic Republic of Congo, and their first language was French. Mr. Ekamba had attended post-secondary studies and had held some work positions. He and his mother were on Ontario Works benefits and were living in public housing. His sister was home-schooling as per her mother's direction, including attending some remote classes.

Prior to the events of March 20, 2015, Mr. Ekamba and his mother had sometimes behaved and spoken in a manner which appeared unusual and, at times unsettling to their neighbours. In hindsight, the unusual behaviour was likely consistent with mental illness. However, neither Mr. Ekamba nor his mother sought medical assistance, and there were no interactions with professionals which would have triggered a referral. Apart from an incident on March 16, 2015 (four days prior to Mr. Ekamba's death) neighbours did not believe the behaviour was sufficiently dangerous or bizarre for them to call police, and were not aware of other resources, such as mental health teams.

On March 16, 2015, Neighbour 'A' called the police to complain that Mr. Ekamba's mother had threatened her following a dispute about the neighbour's cat straying on to the Ekamba's front yard. Police attended and spoke to the neighbour, and Mr. Ekamba and his mother. The attending officers formed the view that both Mr. Ekamba and his mother were experiencing delusions arising from mental illness. The officers spoke to the neighbour about the potential for laying criminal charges, seeking a court order or taking a report to record the events for future reference. Neighbour 'A' advised the police that she was content with a report being taken.

On March 20, 2015, events substantially escalated. Mr. Ekamba and his mother made verbal death threats against Neighbour 'B', who was sweeping a common area outside the houses. Mr. Ekamba's mother threw a knife towards Neighbour 'B', which did not strike her. The incident was filmed, in part, from an upstairs window. Neighbour 'B' withdrew to her house, locked the door, and called police. Police dispatch took the report and advised her that police response would be delayed because of a large number of emergency calls.

Police arrived approximately 6.5 hours after the initial non-emergency call. Three officers entered the home of Neighbour 'B' and viewed the video of the incident. They then went to Mr. Ekamba's home with the intention of arresting him and his mother and charging them with the criminal offence of uttering threats.

Mr. Ekamba came to the door to speak with police. At the time, his mother was boiling some water in the kitchen using a cooking pot. When the officers attempted to arrest Mr. Ekamba, this immediately led to a physical altercation between Mr. Ekamba and the three officers. Mr. Ekamba's mother came out of the house and struck an officer on the head with the pot, after which she was restrained by officers.

During the altercation, Mr. Ekamba stabbed two officers with a knife that he had concealed. He was pepper sprayed and managed to evade the police and run to the back of the townhouse complex. He returned shortly thereafter, likely to assist his mother, who was calling out for help. He approached an officer running while holding the knife in a manner interpreted by the officers as threatening death or serious bodily harm.

Mr. Ekamba ignored commands to stop and drop the knife, and all three officers fired a total of 19 shots from their handguns, of which 11 struck Mr. Ekamba. He collapsed to the ground, still holding the knife tightly. Emergency Medical Services (Ambulance) attended, pronounced Mr. Ekamba dead at the scene, and transported other injured persons to hospital for treatment. One police bullet struck and entered the body of Neighbour 'C', who was standing in the kitchen of her home.

During the discharge of firearms, another police bullet struck one of the officers but was intercepted by a ballistic vest. Both the officer and Neighbour 'C' sustained serious but non-life threatening injuries, which continue to cause them serious physical and psychological complications.

The Special Investigations Unit ("SIU"), which reviews deaths due to police actions, conducted an investigation and did not lay charges. The coroner also investigated and an autopsy was conducted, which showed that Mr. Ekamba died of rapidly and irreversibly fatal multiple gunshot wounds.

Expert Psychiatric Evidence

An expert in Forensic Psychiatry provided fact evidence to the jury.[2] He was briefed on the facts of the case and the evidence presented to the jury. He reviewed the Ontario Review Board rulings concerning Mr. Ekamba's mother, including the likely psychiatric diagnosis.

[2] For clarity, the expert was called to provide general background factual evidence to the jury about mental health crises but was not asked to provide an independent expert opinion about the mental health diagnosis of the deceased, or concerning the police interaction with Mr. Ekamba.

The expert explained the diagnosis documented in ORB documents to the jury. Mr. Ekamba and his mother, both previously well, had jointly developed a rare mental disorder known as "*folie à deux*." In this disorder, two or more people share the same thought disorder. It usually involves two people in a close relationship, one of whom first exhibits the mental disorder, after which the other also manifests it.

Mr. Ekamba and his mother shared a delusion that he was king of the world, and that his throne had been stolen from him by others. Both thought that others wished to cause them harm, and that they needed to defend themselves, by lethal force, if necessary. Mr. Ekamba and his mother, in the weeks prior to Mr. Ekamba's death, had discussed killing Neighbour 'B', as well as staging a confrontation with police during which force would be used. The expert explained that, in such cases, the perceived threat might be from any person, including children or other bystanders. Paranoid delusions can develop quietly. The first interaction with police and other professionals may be an episode of agitation and paranoia, as in this case.

Alternative Responses to Persons in Crisis

The jury also heard evidence that Peel Regional Police has teams which respond to mental health crises, including Crisis Outreach and Support Team ("COAST") and Mobile Crisis Rapid Response Team (MCRRT) Units. These units partner police officers with mental health workers. For safety reasons, these teams are not dispatched until the scene is safe for the mental health workers' attendance.

The situation here involved a person with mental disorder who had inflicted wounds using an edged weapon. Mental health teams would not have been allowed to respond until the danger had been managed.

Edged weapons

The jury heard expert fact evidence from an emergency room physician and trauma team leader. Edged weapons, which include but are not limited to knives, kill more Canadians than guns. Where they do not kill, they can inflict serious injuries causing lifelong disability. Relatively short blades, of five cm (two inches or less) length, can inflict serious wounds which can be rapidly fatal, despite immediate interventions.

Police training

The jury heard fact evidence from a trainer at the Ontario Police College, where police officers receive initial and ongoing training. The trainer explained that officers are taught the Ontario Use-of-Force Model, which 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 that 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 could 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. Kitchen 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.

Effects on Survivors

The jury heard compelling evidence from the sister of the deceased, the bystander who was struck by the stray police bullet, the injured officers, and others who witnessed and were profoundly affected by these events. The circumstances surrounding Mr. Ekamba's tragic death led not only to the loss of a son and brother, but to lifelong psychological and physical injuries to these persons and many others.

THE INQUEST

Dr. Kenneth Peckham, Regional Supervising Coroner for Central Region, Central West Office, called a mandatory inquest into the death of Marc Diza EKAMBA 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 11 days, heard evidence from 20 witnesses, reviewed 104 exhibits and deliberated for 4.5 hours in reaching a verdict.

VERDICT

Name of Deceased:	Marc Diza EKAMBA
Date and Time of Death:	March 20, 2015 at 10:53 p.m.
Place of Death:	3070 Queen Frederica Dr., Mississauga
Cause of Death:	Multiple Gunshot Wounds
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. Ekamba died of an injury that was non-accidentally inflicted by another person. The jury's finding of homicide carries no criminal or other liability, nor should any be inferred.*

JURY RECOMMENDATIONS

To all Ontario Police Services:

1. Improve knowledge and awareness for police communicators, call takers, and dispatchers of the signs of mental health crisis, and ensure that communicators are trained to ask questions directed at determining whether a call involves a mental health crisis.

   Comment: *The non-emergency call taker did not ask Neighbour 'B' about the possibility of mental disorder, even though the description of the event suggested that mental disorder was a factor. Collection of this information and communication to responding officers may have assisted them in preparation and decision-making.*

2. Ensure that police officers responding to a mental health crisis are aware that police have responded previously to incidents involving the same parties and facilitate access for responding officers to significant information regarding previous calls.

Comment: *Responding police officers did not view or have ready access to previous incidents, including the incident on March 16, 2015, that involved the same people.*

3. Ensure that all police officers who interact directly with the public are provided with the four-day mental health training currently provided to incoming police officers in their first year of service. Regular refresher training on mental health issues should be provided to all police officers who interact with the public.

   Comment: *Peel Regional Police officer trainees receive four days of mandatory mental health awareness training. There is no consistent standard or guideline for police services to refresh and update officers on this knowledge after they graduate. Some police services provide this to all or some officers. The jury recommended a consistent approach for all police services.*

4. Ensure that police officers can accurately identify their own Mental Health Act options and explain options available to complainants when a mental health issue is the basis for criminal conduct.

   Comment: *Police officers who testified had incomplete and inconsistent knowledge of the options available under the Mental Health Act when a person is exhibiting behavioural issues, which may be due to mental disorder. Members of the public who contacted police about the disturbing behaviour of Marc Ekamba and his mother were not provided these options.*

5. Continue implementation of the pilot enhanced de-escalation training developed by the Ontario Police College and engage with OPC on its experience with the training and its potential implementation.

   Comment: *The jury supported expanding this initiative.*

6. Ensure that persons with lived experience from peer-run organizations are directly involved in the development and delivery of both mental health crisis and de-escalation training.

   Comment*: The perspective and insight of persons with lived experience enhances the educational experience of officers and informs their future dealings with persons with mental disorder.*

7. Mandate that all Police Service officers receive annual implicit bias and cultural competency training to address stereotyping of Black people, and the existing

research on anti-Black racism in policing.

***Comment**: Anti-Black racism is a pervasive, systemic issue in Canada, including in the criminal justice system. It substantially affects the confidence of Black people in the criminal justice system. Regular refreshers and updates for officers in anti-Black racism will assist in addressing this pervasive issue.*

8. Develop methods to evaluate the effectiveness of mental health, de-escalation and anti-racism training. The evaluation of the effectiveness of such training should include the participation of affected communities, including persons with lived experience from peer-run organizations.

   ***Comment:** Little data is currently collected on the effectiveness of these interventions, so it is not possible to determine how much they improve outcome, and, where there are competing options, which option is most likely to work. The jury recommended capturing such data, then analysing it and reviewing it with appropriate persons, with the goal of improving practice and outcomes.*

9. Develop and implement a pilot project to explore the feasibility of dispatching crisis support workers to mental health service calls that do not require police involvement, similar to Peel Regional Police Mental Health Strategies.

   ***Comment:** Currently, only a police officer is typically dispatched to a report of a person with an apparent mental disorder. In appropriate cases, a professional with specialized mental health crisis skills is a more effective first responder. Peel Regional Police is seeking to implement such an initiative, which the jury recommended be expanded to other police services.*

10. Create emotionally supportive debrief sessions for police officers at the division or platoon level for those involved in critical incidents resulting in serious bodily harm or death, with regard for the Special Investigations Unit investigative process.

    ***Comment:** Circumstances like those surrounding the death of Mr. Ekamba are frequently traumatic to involved police officers. Early access to suitable care may assist the officer(s) but must not compromise the SIU investigation of the incident.*

11. Ensure that witnesses or persons injured during an event that leads to a police-involved death are directed to trauma-informed supports.

    ***Comment:** Circumstances like those surrounding the death of Mr. Ekamba are*

frequently traumatic to witnesses and other bystanders. Early, skilled access to suitable care may assist in managing the trauma.

12. Police Services and Police Services Boards shall establish standing or advisory committees on race and impartial policing and on mental health in order to meet with representatives of peer-run organizations and members of affected communities on an ongoing basis to discuss concerns and facilitate solutions.

    ***Comment**: Black people and persons with mental disorders experience systemic barriers in dealing with police. Ongoing dialog between police services and those communities will assist in improving policing practices, and trust between the communities and police.*

13. Consult with the Ontario Anti-Racism Directorate to analyze race-based data collected by Police Services to measure and evaluate police service performance on use of force, take corrective action to address systemic discrimination and provide clear and transparent information to the public on bias and discriminatory use of force.

    ***Comment:** Reliable data is required in order to enable evaluation of the effectiveness and equity of police interactions. The jury supported collecting complete and accurate data, then acting upon it.*

14. Police Services and Police Services Boards shall establish permanent data collection and retention systems to record race, mental health issues, and other relevant factors on use of force incidents. The data should be standardized, disaggregated, tabulated and publicly reported. The data should include age, gender, perceived race, and officer perception of whether the individual has any mental health issues;

    ***Comment:** See comment at Recommendation #13.*

15. The results of the data collected on use of force incidents must be taught to all frontline Police officers.

    ***Comment:** See comment at Recommendation #13.*

16. Police Services and Police Services Boards shall consult with third parties, including individuals from the Black community, Black advocacy community organizations, persons with lived experiences from peer-run organizations, and appropriate content experts, and:

a. Develop an objective methodology to measure and evaluate police service performance on use of force;
b. Take corrective action to address systemic discrimination; and
c. Provide clear and transparent information to the public on biased and discriminatory use of force.

Comment: *See comment on Recommendation #13. Evidence was heard that police are more likely to use force, and to use more force, when the person is Black and/or has a mental disorder.*

17. Training for new officers should be amended so that the question of the suspect's mental health be as prominent in their considerations as the criminal activity they have committed.

Comment: *Officers testified that the criminal matter was the primary consideration in their interaction with Mr. Ekamba and his mother. This recommendation encourages officers to give greater consideration to a mental disorder when it is a factor in apparent criminal conduct.*

18. Training should be given to establish who should lead the call when dealing with a potentially violent incident or crisis.

Comment: *Evidence was heard that planning by police for the interaction was limited, and no specific officer was in charge.*

Jury's note on Recommendations 1-18:
All Ontario police services should seek and allocate funding and resources adequate to implement the above recommendations.

Comment*: Some witnesses testified that proposed recommendations could not be provided within existing resources. The jury indicated its expectation that recipients of recommendations would actively seek and allocate the necessary resources, and not decline a recommendation strictly on the basis of resources.*

<u>To the Peel Regional Police:</u>

19. Re-evaluate the capacity of COAST and MCRRT teams to meet the growing need for these services in the Region of Peel.

Comment: *Evidence was heard that these services are heavily used, and often unavailable due to call demands or during hours the service is not staffed.*

Jury's note on Recommendation 19:
Peel Regional Police should seek and allocate funding and resources adequate to implement the above recommendations.

Comment: *See Presiding Officer's Comments at Jury's note on Recommendations 1-18.*

To the Ministry of the Solicitor General:

20. The Ontario Use of Force Model should be renamed to accurately capture the intent and purpose of the Model, which is a guide to police engagement with the public rather than to suggest that force is inherent in police interactions.

    Comment: *Changing the name of the model would emphasize that it governs police interactions with members of the public, de-escalation where possible, and appropriate use of force, if required.*

21. The Ontario Use of Force Model shall be redesigned to highlight and emphasize the importance of de-escalation at all points during police interactions.

    Comment: *See comment at Recommendation #20.*

22. The Ontario Police College shall ensure that persons with lived experience are engaged in the development and delivery of de-escalation training.

    Comment*: Persons with lived experience can provide vital insight to police officers concerning de-escalation and use of force.*

23. The Ontario Police College shall ensure that affected communities and persons with lived experience be directly engaged in the development and delivery of anti-bias training. OPC should ensure that community organizations who represent persons with lived experience are engaged in this work.

    Comment: *See comment at Recommendation #22*

24. Revise the Use of Force Report form to require officers to document de-escalation techniques used.

Comment: *See comment at Recommendation #13. This recommendation builds on Recommendations #13 – 16, by enabling detailed data of police interactions, tactics employed, and outcomes.*

To the Ministry of the Solicitor General and Peel Regional Police:

25. There must be special recognition of the unique challenges Black people who also have serious mental health issues face when they come into contact with police. This unique intersection of Blackness and lived experience of mental health issues must be specifically addressed in any training on Use of Force, de-escalation, and police interaction with such persons.

Comment: *The jury heard evidence that Black persons with mental health disorders are at particular risk of negative outcomes from interactions with police.*

Jury's note on Recommendation 25:
The Ministry of the Solicitor General and Peel Regional Police should seek and allocate funding and resources adequate to implement the above recommendations.

Comment: *See Presiding Officer's Comments at Jury's note on Recommendations 1-18.*

To the Government of Ontario:

26. Commission a study to examine the creation and implementation of a province-wide, civilian-led crisis intervention system to respond to persons in crisis, including mental health crisis. This team should be staffed by trained mental health professionals, crisis intervention professionals, and persons with lived experience.

Comment: *This recommendation reflects the areas identified by the jury in the previous recommendations. The current Model, in which police are the presumptive first responders to disturbing behaviour, may be improved by dispatching mental health professionals as first responders, when appropriate and safe. A mental health professional has skills and experience different from that of a police officer, skills that would assist in achieving optimal outcomes in safe and effective management of mental health crises.*

27. Improve public awareness of mental health issues to counteract stigma and discrimination against persons with mental health issues. Measures to improve

public awareness should be developed in consultation with content experts and community organizations that represent persons with lived experience.

Comment: *Discrimination against persons with mental disorders is common and based upon lack of knowledge. The discrimination often includes unnecessary fear of persons with mental disorder. Such education will, among other things, reduce the social isolation which represents an additional and unnecessary challenge for persons with mental disorders.*

28. Improve public awareness of both policing and non-policing community-based crisis responses to mental health crisis. Efforts to improve public awareness of these options should be developed in consultation with content experts and community organizations that represent persons with lived experience.

    Comment: *In the time leading up to this incident, neighbours were aware of the sometimes concerning behaviour of Mr. Ekamba and his mother, but did not feel that notification of police was required, and were unaware that there were options for mental health response other than police.*

29. Enhance information and supports available to families of persons experiencing mental health crisis with respect to community-based options to support their loved ones.

    Comment: *Mr. Ekamba's sister, who was 16 at the time of the March 20, 2015 incident, was unaware of available options and, as a teen, would not have felt comfortable initiating a response to the changes in her brother and mother, without professional guidance to assist her.*

30. Improve public awareness and knowledge of community-based supports for persons experiencing mental health issues should target young people and utilize channels of communication that are accessible and suitable for youth.

    Comment: *See comment at Recommendation #29.*

31. Rename crisis hotline services and create awareness campaigns to educate the public about their existence to make the public aware that these services are available before a person reaches the point of crisis.

    Comment: *See comments at recommendations #26 – 30.*

    Jury's note on Recommendations 26-31:
    The Government of Ontario should allocate funding and resources adequate to

implement the above recommendations.

Comment: *See Presiding Officer's Comments at Jury's note on Recommendations 1-18.*

To Peel Housing Corporation:

32. Improve mental health awareness of housing support personnel and, in particular, concerning the recognition of mental health crisis.

    Comment: *Some neighbours notified their landlord, the Peel Housing Corporation ("PHC") about the sometimes concerning behaviour of Marc Ekamba and his mother. PHC did not have a structured procedure to respond to such complaints, including the ability to advise neighbours of programs available for response to persons in mental health crisis.*

33. Ensure that housing support personnel are aware of both the policing and community-based options available to respond to mental health crisis.

    Comment: *See comment at Recommendation #32.*

34. Ensure that housing support personnel communicate the options for both the policing and community-based options to address mental health crisis to affected tenants.

    Comment: *See comment at Recommendation #32.*

35. Review and improve training to housing support personnel on cultural competency, anti-Black racism, implicit bias, mental health and its intersectional nature.

    Comment: *See comment at Recommendation #32.*

Jury's note on Recommendations 32-35:
Peel Housing Corporation should seek and allocate funding and resources adequate to implement the above recommendations.

Comment: *See Presiding Officer's Comments at Jury's note on Recommendations 1-18.*

CLOSING COMMENT

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

I would like to thank the witnesses and parties to the inquest for their thoughtful participation, and to thank my 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.

August 11, 2022

Dr. David Eden
Presiding Officer

Date

APPENDIX A

STATEMENT OF SCOPE

Inquest into the death of Marc EKAMBA

This inquest will look into the circumstances of the death of Mr. Ekamba and will examine the events of their deaths in order to assist the jury answer the five questions and making any recommendations.

The five questions are:

1. Who was the deceased?
2. When did he come to his death?
3. Where did he come to his death?
4. How did he come to his death?
5. By what means did he come to his death?

Included in the scope and focus will be the following issues:

A. How police interact with a person who:
   a. Is, or appears to be under the influence of a mental disorder; and,
   b. Is 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 deaths of Mr. Ekamba 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. Ekamba;

   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. Racism: To the extent that it was present in this interaction, the role of racism and cultural sensitivity;

6. Bystander bullet injuries: The prevention of gunshot wounds to persons in the vicinity of, but not directly involved in an incident in which police use firearms.

C. Exclusions

The following are excluded from scope, except insofar as necessary to answer the 5 questions cited above, or otherwise ruled necessary by the Coroner in order to inform jury recommendations:

1. Emergency response following the incident; and,

2. The investigation of the death by SIU and Peel Police.

Appendix 'B' – Ontario Use of Force Model