

**IN THE MATTER OF THE THOMAS R. BRAIDWOOD, Q.C.,  
COMMISSIONS OF INQUIRY UNDER THE *PUBLIC INQUIRY ACT*,  
SBC 2007, c. 9**

Strategy Room 320  
Wosk Centre for Dialogue  
580 West Hastings Street  
Vancouver, B.C.

May 13, 2008

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PROCEEDINGS AT  
FORUM (DAY 7)

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**ORIGINAL**

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Commissioner:	T.R. Braidwood, Q.C.
Commission Counsel:	A. Vertlieb, Q.C.
Associate Commission Counsel:	P. McGowan
Court Recorder:	P. Kealy, C.V.R., C.M.
Transcriber:	P. Kealy

1  
Dr. Lu Shaohua (Medical presenter)  
Questions by Mr. Vertlieb

1 Vancouver, B.C.  
2 May 13, 2008  
3

4 THE COMMISSIONER: Good morning, everyone. Yes,  
5 counsel.

6 MR. VERTLIEB: Mr. Commissioner, our first presenter  
7 this morning is Dr. Lu, and he is here at the  
8 presenter's table.  
9

10 DR. LU SHAOHUA, a Medical  
11 presenter.  
12

13 Dr. Lu, thank you so much for coming. We  
14 appreciate your time.  
15

16 QUESTIONS BY MR. VERTLIEB:  
17

18 Q Dr. Lu, we just want to deal briefly with your  
19 background.

20 A Okay.

21 Q You are a psychiatrist?

22 A Yes.

23 Q Now, tell us about your education.

24 A I have my undergraduate education in UBC as well  
25 as my medical school. I completed my internship  
26 in Dalhousie and I completed my psychiatry  
27 residency in Ottawa, and I did a clinical  
28 addiction psychiatry fellowship at Harvard.

29 Q And that was at Massachusetts General?

30 A Yes.

31 Q When did you finish med school?

32 A 1993.

33 Q And when did you do your internship?

34 A 1994.

35 Q When did you become specialized in the field of  
36 psychiatry?

37 A 1998.

38 Q In what year were you licensed to practise  
39 medicine in British Columbia?

40 A 1999.

41 Q Now, tell us about your present work in the field  
42 of psychiatry. Where are you situated and what  
43 type of work are you doing?

44 A Currently my clinical work is mostly at Vancouver  
45 General Hospital. I work in the Consultation-  
46 Liaison Service, meaning looking after the medical  
47 and surgically ill patients who have psychiatric

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1 conditions. I also most recently worked at UBC  
2 running a Concurrent Disorder Unit, looking after  
3 patients who have severe addictions and mental  
4 health problems.  
5 Q Now, when we first met, we came together for  
6 discussion because your name had been given to us  
7 by one of the police agencies as someone who might  
8 have some knowledge in the area. You understood  
9 that's how we first placed the phone call to you  
10 to discuss your thoughts?  
11 A Yes.  
12 Q And I'd like to go through, then, just very  
13 briefly what it is that you're actually doing in  
14 the clinical side of your work.  
15 A Okay. Clinically I assess patients with  
16 psychiatric conditions, may it be in an emergency  
17 setting or in a medical surgical unit. I look  
18 after a lot of folks with addiction problems and  
19 severe mental illness such as schizophrenia and  
20 bipolar. In terms of delirium, working at the  
21 Medical Surgical Unit in Vancouver General  
22 Hospital, I see patients with delirium every day,  
23 meaning patients with confusion, disorganization  
24 as a result of surgery, medical problems and other  
25 conditions.  
26 Q And the opinions you're forming and the diagnoses  
27 that you're making, are these coming from seeing  
28 people in the hospital setting?  
29 A Yes.  
30 Q So in other words, you're not going out to some  
31 street corner and watching somebody and making a  
32 diagnosis?  
33 A No. Although I worked in an emergency psychiatry  
34 unit for about seven years, and so we do see a lot  
35 patients who are brought in off the street,  
36 meaning they have no previous assessment,  
37 treatment, and they're straight from the street  
38 into the hospital setting. So I do have a lot of  
39 experience looking after patients in that setting.  
40 Q Yes. But that's in a hospital setting, is what  
41 I'm getting at.  
42 A Yes.  
43 MR. VERTLIEB: Well, then, Dr. Lu, with that  
44 background, perhaps you could start your  
45 presentation for the Commissioner.  
46  
47

1 PRESENTATION BY DR. LU:  
2

3 A This is an introduction on delirium. I'm going to  
4 go straight into the presentation itself.  
5 Delirium is actually poorly defined and poorly  
6 understood in many ways. There are a lot of  
7 different terminologies to describe the term  
8 "delirium" - acute confusional state, acute  
9 organic brain syndrome - all of which try to  
10 capture the fact that delirium affects the brain  
11 in a generalized fashion.

12 Probably this is as good of a definition as  
13 any. This is from the *Diagnostic and Statistical*  
14 *Manual, Volume IV*, with the criteria. This is the  
15 general manual that psychiatry uses in terms of  
16 helping us diagnose a particular condition.  
17 Delirium really is a disturbance of the conscious  
18 mind with reduced ability to focus and to sustain  
19 attention. And I will go into specific details  
20 about what those statements mean.

21 There is also changes in cognition or the  
22 development of a perceptual disturbance.  
23 Perception is our sensorium, meaning our hearing,  
24 our vision, but it's not better accounted for by  
25 pre-existing dementia, meaning patients with  
26 dementia at times can present with similar  
27 problems; however, delirium has its own specific  
28 disturbances. And it's usually developed over  
29 short periods of time and fluctuates over the  
30 course of a day. However, there are rare cases,  
31 for example in patients with dementia, who have a  
32 superimposed delirium that the disturbance can  
33 develop over substantial periods of time. But by  
34 and large, for younger individuals, delirium is  
35 something that occurs relatively over a short  
36 period of time.

37 In terms of definition, the first statement  
38 captures what delirium is all about. It's a  
39 generalized cognitive and brain dysfunction.  
40 Specifically, it impairs the level of  
41 consciousness. An individual can present as  
42 drowsy or agitated. Most importantly, there is a  
43 disrupted sleep-wake cycle. Individuals wake up  
44 tired, they might not be able to sleep. Often  
45 during what we call the sundowning periods toward  
46 the end of the evening, agitation is more common.  
47 By and large, most patients with delirium will

1 exhibit some degree of changes in their level of  
2 consciousness, and it's a waxing and waning cycle,  
3 sometimes more alert, sometimes more drowsy.

4 Attentional deficits. There is  
5 disorientation. In the mild degree, they might  
6 not know what time it is. In the most severe  
7 situation, an individual might not even know who  
8 they are. So that's the kind of disorientation  
9 that might happen.

10 There is poor attention and concentration, so  
11 the ability to sustain attention over probably  
12 even as long as two minutes in the severe cases  
13 can be difficult. So in other words, they might  
14 have difficulty following basic instructions due  
15 to the problem with attention and concentration.

16 Impaired comprehension and speech. In that  
17 delirious state of poor attention and changes in  
18 cognition, a person will have difficulty  
19 articulating their thoughts or in understanding  
20 basic instructions. It's not unusual because of  
21 the language deficit and impaired comprehension,  
22 relatively polite older ladies can swear. They  
23 might appear more aggressive than they otherwise  
24 would because of the language difficulties and  
25 deficits.

26 Memory deficit is quite common. Mostly it's  
27 the impaired short term and working memory, so  
28 what happened two minutes ago, five minutes ago.  
29 So in combination with disorientation, poor  
30 attention, concentration and memory deficit, a  
31 person might have difficulty answering basic  
32 questions like "What are you doing?" "Where are  
33 you?" "What is happening?" So those are the  
34 kinds of basic impairments that present in itself  
35 when the patient is suffering from delirium.

36 There is what we call executive cognitive  
37 function impairment. That is decreased ability to  
38 plan, organize and execute tasks. So any kind of  
39 complex demand can be difficult. There is  
40 generalized disorganization and impaired insight.  
41 Impaired insight is a really important aspect of  
42 delirium. They don't know what's happening is not  
43 real or they don't have an appreciation that they  
44 are in a disorganized state.

45 This leads to the next part, which is the  
46 thought disturbance. It's not unusual for  
47 patients with delirium to have delusional thinking

1 and illogical thought process. So in the mild  
2 state, a patient might just have a vague feeling  
3 that something is wrong. In prolonged or more  
4 severe delirious state, highly systematized  
5 delusional thinking can occur, so for example,  
6 being abducted. In hospital because of the  
7 machines and wires, it's not unusual for elderly  
8 patients to think that they're being experimented  
9 upon. Sometimes some of the delusional thinking  
10 might be related to old background. So for  
11 example, it's not unusual to see elderly Asian men  
12 all of a sudden thinking that they're back in  
13 World War II because of being restrained and not  
14 really knowing where they are.

15 Those kind of delusional thinking occurs due  
16 to a disrupted thought process, and that can lead  
17 to some potentially bizarre behaviour because  
18 they're responding to their internal disturbed  
19 thought process.

20 The affect is also changed. It's more  
21 labile. An individual can be sad, frightened  
22 rapidly. In rare cases - and I would say, having  
23 seen probably well over a thousand patients with  
24 delirium - I have seen a grand total of two  
25 patients who actually have happy delirious  
26 thoughts. By and large, because if you're in a  
27 scary place, you don't know where you are, the  
28 chance of having a happy delusion is rare. Most  
29 of the patients with delusions are scared,  
30 frightened, and in a state of anxiety and  
31 irritability. Rarely do I actually see an  
32 individual actually find their delirious state a  
33 pleasant one.

34 Perceptual disturbance can occur. That  
35 really is a misinterpretation of both external and  
36 internal stimuli. A case in point is a patient I  
37 saw yesterday. She's in a hospital bed. The next  
38 bed has IV machines that go off in sound and she  
39 thought that sound is a fire alarm and she needs  
40 to get out of there. So that misinterpretation of  
41 internal and external stimuli is quite common.

42 Hallucination may or may not present. It  
43 depends on the degree and the severity of the  
44 delirious state. By and large, visual  
45 hallucination is more common than auditory  
46 hallucination, seeing things, birds in the room.  
47 Tactile hallucinations or somebody touching them,

1 that can be quite frightening. By and large, for  
2 most patients there is a degree of agitation and  
3 restlessness that goes along with delirium. In  
4 rare cases we have what we call apathetic delirium  
5 where an individual just lies in bed looking  
6 depressed but they are actually in a delirious  
7 state. That's not common.

8 By and large, agitation and restlessness  
9 happen. And that restlessness and agitation can  
10 have a quite profound impact on an individual's  
11 strength. I have seen elderly ladies in their 70s  
12 or 80s who can take on three security guards,  
13 because in that state of loss of internal monitor,  
14 there's a tremendous display of strength. And I  
15 use the term "defensive aggression." What I mean  
16 by that is the aggression is rarely directed to  
17 any specific individual. So for example, a nurse  
18 going in to change dressing, to talk to a patient,  
19 to offer medication, can be interpreted internally  
20 because of the disturbed perception and thought  
21 process as an intrusion into the personal space of  
22 the patient and they react aggressively. And that  
23 aggression is not meant to harm or meant to hurt  
24 somebody. They're just frightened. And that  
25 defensive aggression is not unusual. Barricading  
26 themselves, throwing things -- that is a  
27 frequently encountered component of delirium.

28 I have heard the term "excited delirium"  
29 being used in various different presentations in  
30 the past. And I just want to say that in the  
31 medical surgical standpoint and even a psychiatric  
32 standpoint, we do not use that term. In our  
33 understanding, most patients with delirium are in  
34 an excited and agitated state. My understanding  
35 of excited delirium is really the patient with  
36 delirium with a highly agitated and extremely  
37 restless presentation, so the more severe spectrum  
38 of delirious presentation. But from a medical and  
39 surgical standpoint, we don't really use that term  
40 because our understanding is most delirium has an  
41 agitated component.

42 Delirium is a medical, physiological response  
43 to external insults. Almost always patients with  
44 delirium will have what we call autonomic  
45 instability, rapid breathing, sweating, increased  
46 heart rate, unstable blood pressure. Those are  
47 the physiological responses to the changes in

1 perception. I already talked about that. It  
2 generally happens rapidly. It has a fluctuating  
3 course.

4 It's important to know that delirium is not a  
5 medical disease. It is a syndrome and it is a  
6 symptom of many underlying problems. So it is  
7 like pain. Pain occurs in a variety of  
8 situations. It's not a disease in and of itself.  
9 And delirium is not a medical disease in and of  
10 itself. Rather it is a reflection of multi-  
11 aetiology, risk and vulnerability, and I'm going  
12 to talk about that next.

13 So what are the predisposing and risk  
14 factors? Age. The older a person, the more  
15 likely they're going to get delirious, which also  
16 tells you that if a younger individual - the  
17 younger the individual, the healthier they are -  
18 if they become delirious, something is medically  
19 wrong with them. Dementia, individuals with  
20 dementia are much more prone to develop delirium.  
21 Again, it doesn't take that much for an individual  
22 with dementia to lose their sense of bearing,  
23 orientation, and their internal thought control.

24 Medical co-morbidity. The more severe the  
25 medical problem, the more likely that the  
26 individual is going to get delirious. History of  
27 alcohol abuse, both intoxication and withdrawal.  
28 Male sex, for some reason, has an increased  
29 predisposition. Sensory impairment, particularly  
30 vision and hearing. Again, it goes to the  
31 individual's ability to make sense of the external  
32 world. Unfamiliar setting. Language barrier,  
33 Dehydration. All of those are predisposing and  
34 risk factors associated with the onset of  
35 delirium.

36 What puts the person over the edge and  
37 generate a delirious state? It can be as simple  
38 as environmental change. For an elderly demented  
39 patient, for example, pain. Emotional and social  
40 isolation for extended periods of time. Prolonged  
41 sleep deprivation. And when I say that, I'm  
42 usually talking about at least 24 to 36 hours,  
43 particularly in a vulnerable individual.  
44 Interestingly, long haul flights, particularly  
45 from east to west, so from Asia to North America  
46 and that sort of east to west, tends to have a  
47 slightly increased risk as well. That's probably

1 because most people fly, have a full day, whole  
2 day. They didn't sleep, they get on the plane,  
3 and they get into Vancouver and it's still sunny.  
4 We certainly have seen prolonged sleep deprivation  
5 as a cause of delirium. The same thing with  
6 elderly patients. And in fact, one of our  
7 treatments in Vancouver General Hospital in  
8 dealing with delirium is to normalize sleep. We  
9 find that unless a patient has normalized sleep,  
10 the delirium rarely gets better.

11 Prolonged sensory deprivation or prolonged  
12 sensory stimulation. So for example, patients who  
13 are in intensive care where they're surrounded by  
14 machines, sounds, a beeping noise, they can get  
15 delirious simply because it is so overwhelming in  
16 the sensory stimulation.

17 Metabolic disturbances, meaning dehydration,  
18 electrolyte changes to the body. All of those are  
19 potential precipitating factors.

20 Of course other ones include medical problems  
21 such as neurological conditions such as a stroke,  
22 head injury, surgery itself, medical illness,  
23 trauma, anaesthetic exposure, infection, and the  
24 list goes on. The differential for potential  
25 precipitating factors for delirium is a massive  
26 list and it would be too exhaustive to go through  
27 each and every one of them in this presentation.

28 Drugs and medications. Hypnotosedatives.  
29 Although normalizing sleep is important, however  
30 for some individuals a low dose of benzodiazepine,  
31 for example, can precipitate a delirious state  
32 because of the disinhibiting effects associated  
33 with sedative hypnotics. Opiates. It could be a  
34 simple dose of morphine for pain to heroine use.  
35 Anticholinergic drugs. That means medication that  
36 blocks a specific neural pathway. Cocaine and  
37 psychostimulants are highly precipitating agents  
38 for delirium.

39 Alcohol withdrawal is probably the one that  
40 we see the most. In acute alcohol withdrawal,  
41 particularly in combination with any of the  
42 earlier risk factors, delirium can occur quite  
43 rapidly. Sedative withdrawal is similar  
44 withdrawal.

45 And this is really probably the best way to  
46 look at delirium. We use the term "vulnerability  
47 liability model." So vulnerability. So the more

1 vulnerable the individual, so an elderly  
2 individual with dementia and multiple medical  
3 problems, all they need is just a small  
4 environmental change. Moving from one room to  
5 another can precipitate delirium. On the other  
6 hand, a young and healthy individual, they require  
7 a much higher noxious insult, so multi-trauma.  
8 It's not unusual for us to see a 25-year-old  
9 healthy young individual in a major motor vehicle  
10 accident with multiple trauma and they don't get  
11 delirious, whereas an elderly individual, a simple  
12 flu can cause delirium, a delirious state.

13 On the other hand, a young and healthy  
14 individual, if they do present with delirium, one  
15 has to be much more cognizant of potential medical  
16 problems such as alcohol withdrawal, dehydration  
17 and other medications.

18 So that's a really good way to kind of look  
19 at the predisposing factors and vulnerabilities  
20 and the precipitating event. The more vulnerable  
21 the individual, the less noxious insult is  
22 necessary to precipitate delirium. The healthier  
23 the individual, the more trauma and more medical  
24 problems are necessary to get into that state.

25 Delirium has a high morbidity. It's a  
26 leading cause of prolonged hospitalization and  
27 associated problems, and you can well imagine, for  
28 example, an individual who has delirium wants to  
29 get out of bed and they fall and fracture a hip.  
30 It certainly increases mortality.

31 Having said that, despite the common  
32 presentation of delirium, it is difficult to  
33 diagnose even in a medical setting. It's not  
34 unusual even for somebody like myself, who sees  
35 delirium on a regular basis, and we are not 100  
36 percent certain whether or not a patient is in a  
37 delirious state versus an extreme depression or  
38 psychosis. And the fact of the matter is, it  
39 doesn't really matter all that much in terms of  
40 treatment, particularly in the acute phase. In  
41 extreme cases, it is a medical emergency.

42 Again, in otherwise healthy individuals,  
43 sudden onset of delirium may be warning signs of  
44 potential life-threatening metabolic changes or  
45 extreme fatigue and exhaustion.

46 Going back to this slide, because delirium  
47 for a relatively young and healthy individual

1 requires a highly noxious insult to precipitate a  
2 delirium, additional insult, whatever that might  
3 be, can really lead to cardiac arrest and sudden  
4 death.

5 How do you manage delirium? Well,  
6 particularly in the mild to moderate situation,  
7 social restraint is the best. What do I mean by  
8 that? Social restraint means familiar  
9 environment, low stimulation, put the person in a  
10 comfortable, familiar setting, orienting stimuli,  
11 a big clock, somebody who they know. So for  
12 example, an elderly Asian man who doesn't speak  
13 English, in hospital, beginning to develop  
14 delirium, if they have a family member goes in and  
15 speaks their own language, it calms a person down  
16 right away. So for example, sometimes I go in and  
17 my students think that I can perform magic, but  
18 it's not, you know. It's just because I can speak  
19 Cantonese or Mandarin to the patient, and they  
20 know that they're not being experimented on and  
21 this is in hospital and I'm here to help. So that  
22 basic social familiarity makes a world of  
23 difference.

24 Rehydration. There is a patient who is  
25 dehydrated. Normalizing sleep. Correct the  
26 underlying medical problem, of course, if there is  
27 an infection going on.

28 Occasionally none of those things work  
29 because the patient is agitated, they're  
30 frightened, they're fearful, and they're agitated  
31 and they're restless. They need to be in a  
32 physical restraint from harming themselves or  
33 taking off. In hospital we almost always, except  
34 in really rare, rare situations -- if a patient is  
35 restrained physically, we use pharmacological  
36 treatment to help to decrease that agitation as  
37 soon as possible. The safest one is probably  
38 benzodiazepine or antipsychotic, and we use that  
39 interchangeably. It depends on the age and the  
40 underlying medical condition, if we know, that is  
41 causing the delirium, and also the degree of  
42 agitation and combativeness that the individual  
43 displays.

44 In terms of suggestions for first  
45 responders - and I'm talking specifically perhaps  
46 to, because of this inquiry, police - and I use  
47 the term "education" not so much in terms of

1 recognizing delirium. Frankly, when a patient is  
2 in a direct delirious state, it would be difficult  
3 to tell whether or not it is due to cocaine or  
4 methamphetamine, psychosis, extreme psychosis as a  
5 result of untreated schizophrenia or severe  
6 bipolar. That type of education I'm not too sure  
7 is particularly helpful because I would have a  
8 tough time distinguishing that, and I don't see  
9 that type of education would be helpful. But  
10 recognizing that a delirious patient can have  
11 autonomic changes such as sweat, disorganization,  
12 disorientation, and that they can have defensive  
13 aggression perhaps would be helpful.

14 Training and recognition on how to talk to  
15 the patient and calm them down. Again, the  
16 patients are in a frightened and scared situation.  
17 They might not be able to follow basic  
18 instructions such as "Put your hands down," and to  
19 recognize that is a potential issue.

20 Use of containment whenever possible to buy  
21 time to bring in familiar support. Medical  
22 paramedic backup as soon as possible if a patient  
23 is identified as a delirious state.

24 Again, going back to the medical risks  
25 associated with delirium, be aware of the risk of  
26 restraints and energy weapons. I don't know what  
27 those risks are but I suspect there might be some.  
28 Be aware of those risks.

29 And if a patient is under custody during  
30 delirium, frequent monitoring of basic vitals such  
31 as heart rate, breathing rate and level of  
32 consciousness.

33 In that severe agitated delirious state -  
34 again, I cannot envision a law enforcement agency  
35 being able to do those - but, if there is medical  
36 backup, sedation, oxygen, IV fluids, cooling  
37 measures. And cooling measures is actually found  
38 to be really helpful, particularly for young males  
39 whose delirium is caused by cocaine or crystal  
40 methamphetamine or other drug-induced agitated  
41 state. Low stimuli environment as soon as  
42 possible. And again, going back to the potential  
43 for sudden death, maybe availability of portable  
44 defibrillators.

45 So those are kind of off the top of my head.  
46 Having treated delirium patients for close to ten  
47 years, I would make those recommendations.

Dr. Lu Shaohua (Medical presenter)  
Questions by Mr. Vertlieb (cont'd)

1 I'm going to end my presentation here and  
2 answer questions that you may have.

3 THE COMMISSIONER: Counsel, do you need a break or  
4 you'll continue on?

5 MR. VERTLIEB: No, that's fine, thank you, Mr.  
6 Commissioner. We can just proceed. We can take a  
7 break after the witness, please.

8

9 QUESTIONS BY MR. VERTLIEB, continuing:

10

11 Q Dr. Lu, tell us about the DSM-IV, what it is for  
12 the medical community.

13 A The DSM-IV is a manual for helping to diagnose  
14 psychiatric conditions or psychoneurological  
15 conditions, in this case delirium. As of yet, in  
16 psychiatry we don't have blood tests to say this  
17 individual has schizophrenia, this individual has  
18 bipolar. There isn't a medical, a procedural  
19 diagnosis to help us make those determinations.  
20 For example, the issues of depression. Most of us  
21 have gone through some depressive state sometime  
22 in our lives. Yet, to have the diagnosis of  
23 depression is a medical condition. And so how do  
24 we define the limits of just going through a bad  
25 stretch versus the medical diagnosis of  
26 depression? We use a basic statistic manual and  
27 say, if we go through a number of criteria, and if  
28 this individual fulfils those sets of criteria,  
29 chances are more likely than not they have a  
30 psychiatric condition that is not merely a state  
31 of being depressed because of whatever  
32 psychosocial stressors that are going on at the  
33 time, that they actually have the psychiatric  
34 diagnosis of depression as a result.

35 Q So the DSM-IV is a manual, it's a book. And it's  
36 a big book. It's a few inches thick perhaps. And  
37 it's used regularly by psychiatrists?

38 A Yes.

39 Q But it's also used by family doctors?

40 A Yes.

41 Q It's used by many medical people to help them come  
42 to diagnosis in the field of mental illness?

43 A Yes.

44 Q The DSM-IV is recognized throughout Canada and the  
45 United States?

46 A Yes.

47 Q Would that be considered perhaps by most doctors

Dr. Lu Shaohua (Medical presenter)  
Questions by Mr. Vertlieb (cont'd)

1 to be the bible, as it were, on the subject of  
2 diagnosis of mental illness, for categorization?  
3 A It is probably the most helpful tool, yes.  
4 Q Is there a category in the DSM-IV for the term  
5 "excited delirium"?  
6 A As far as I know, no.  
7 Q Now, you were talking about somebody who was in  
8 the medical state of delirium and you've told the  
9 Commissioner about the challenges in coming to  
10 that conclusion. You've said that such a person  
11 could have difficulty following basic  
12 instructions.  
13 A Yes.  
14 Q So give a couple of examples of what you mean by a  
15 basic instruction.  
16 A "Squeeze my hand." "Open your mouth."  
17 Q What about in the police setting, when the police  
18 attend and give a basic instruction? Give an  
19 example of that where a person might not be able  
20 to comprehend.  
21 A Yes.  
22 Q You mentioned putting your hands up.  
23 A Putting your hands up. Put down a certain object.  
24 Q So if a person was in that state, a simple command  
25 or however you want to call it from the police  
26 might not be understood?  
27 A May not be understood or may be misinterpreted in  
28 ways that they might have understood but they  
29 might not perform due to their internal confusion  
30 and thought process.  
31 Q Now, then you also went on to say that the person  
32 could appear more aggressive. Just expand on that  
33 for a moment.  
34 A The individual, as I say, often is in a frightened  
35 state. Again, having seen close to a thousand  
36 delirious patients, I probably have seen only two  
37 individuals who have happy delirium, and the rest  
38 are frightened, scared. And when you're  
39 frightened and scared, it's a fight or flight  
40 response that is basic to human nature. And in  
41 that state, aggression is not uncommon.  
42 Q So are you saying to the Commissioner that the  
43 person could appear to be aggressive but in fact  
44 not really at their core be aggressive?  
45 A No, no, no. They can be aggressive. Not just  
46 appear aggressive but they are aggressive. You  
47 can have both, in the sense that, for example --

1           this is a perfect example. A patient believes  
2           that somebody is going to kill them in the middle  
3           of the night. They're going to leave here, and if  
4           you're going to stop them, they're going to be  
5           aggressive. And they don't just appear  
6           aggressive; they will be aggressive.

7           Q     And that's the defensive aggression, the --

8           A     Yes.

9           Q     -- aggression you talked about. So a person may  
10          appear to be aggressive and in fact be that way.

11          A     Yes.

12          Q     Or appear to be aggressive and really not be that  
13          way?

14          A     Yes.

15          Q     So that becomes another challenge in trying to  
16          figure out what's happening to a person who's in  
17          some kind of state?

18          A     Yes. And even more scary sometimes is when  
19          patients have what we call partial insight. They  
20          know something is wrong but they can't really  
21          articulate, and if you try to talk to them, you  
22          must be part of it. And so sometimes even trying  
23          to get the patients to talk about what is actually  
24          going on in their thought process can be  
25          difficult.

26          Q     But that's the reason you want to speak to people  
27          so that you can try to understand what's  
28          happening?

29          A     Sometimes that can be difficult too. Obviously we  
30          try our best to understand what's going through in  
31          the patient's mind. However, occasionally, due to  
32          the language comprehension difficulties and the  
33          internal disorganized thought process and the  
34          paranoia that occasionally can occur that you're  
35          part of the whole system, then attempts to  
36          communicate may be impaired.

37          Q     So is that part of the reason you are speaking to  
38          the Commissioner about the need for calmness and  
39          slowing things down to allow the environment to  
40          become better?

41          A     I think the calm approach is always recommended in  
42          this kind of situation.

43          Q     Now, I wanted to ask you something about delirium.  
44          You said it is not a disease.

45          A     No.

46          Q     And I think every medical doctor in the continent  
47          would agree with that. Delirium is not a disease.

Dr. Lu Shaohua (Medical presenter)  
Questions by Mr. Vertlieb (cont'd)

- 1 A Delirium is a manifestation of a whole host of  
2 stressors impacting on the physiological function  
3 of the brain.
- 4 Q And you then went on to say to the Commissioner  
5 that delirium is really a collection of symptoms.
- 6 A Yes.
- 7 Q Now, it may be self-evident to you as a doctor,  
8 but to us as non-medically trained people, a  
9 patient does not die from symptoms. They die from  
10 underlying medical disease or condition. Is that  
11 a fair statement?
- 12 A That's a fair statement.
- 13 Q Now, I wanted to ask you about the effect of  
14 cocaine on a person's heart rate. What is it,  
15 please?
- 16 A Cocaine is what we call a psychostimulant. It  
17 certainly has a stimulating effect on the  
18 individual. It acts in a number of different ways  
19 on the heart. It has a direct stimulation effect  
20 on the cardiac function of an individual,  
21 particularly during the acute intoxication stage,  
22 particularly for individuals who are naïve to  
23 cocaine. Over periods of time, chronic users have  
24 a response that is slightly different. But let's  
25 say for a naïve individual - when I say naïve,  
26 meaning that they haven't been exposed to  
27 cocaine - meaning there will be increases in heart  
28 rate and increase in oxygen demand. And it is  
29 what we call a rhythmogenic drug, meaning that it  
30 can potentially disrupt the rhythm of the heart.  
31 And in combination with alcohol in particular,  
32 particularly a lower dose of alcohol rather than a  
33 large amount of alcohol, cocaine can also form  
34 addition compounds that stimulate the speed of the  
35 heart.
- 36 Q So as a stimulant to heart function, it would  
37 increase the heart function?
- 38 A Yes.
- 39 Q It would not be a tranquilizing effect at all; it  
40 would be the opposite?
- 41 A It should be the -- yes.
- 42 Q And so if you had a person who's in some kind of  
43 issue with drugs, cocaine for example, or crystal  
44 meth or any other drugs that you're seeing, they  
45 would have a risk of increased heart activity?
- 46 A Not all other drugs. Cocaine and other  
47 psychostimulants such as crystal methamphetamine

- 1 increases heart rate. Other drugs, for example  
2 heroine, doesn't. Benzodiazepine, GHB doesn't.  
3 Although GHB occasionally can, but that's a  
4 different story. Alcohol withdrawal increases  
5 heart rate. Alcohol intoxication decreases it.  
6 So cocaine in itself, particularly in -- cocaine  
7 and other psychostimulants, such as crystal  
8 methamphetamine, or any amphetamine, I should say,  
9 increases heart rate.
- 10 Q Now, you mentioned that in the hospital setting  
11 you will use restraint but you do so with a  
12 sedating medicine.
- 13 A Yes.
- 14 Q So you do have occasion in the hospital setting  
15 where somebody is in such a state that they need  
16 to be restrained, but you do so with sedation?
- 17 A We try to do that. Sometimes that's a balance,  
18 because too much sedation for certain individuals  
19 increases the risk for pneumonia and aspiration  
20 and so on. But generally speaking, imagine an  
21 individual who is frightened and they're tied  
22 down, what they're going to do. They're going to  
23 fight it. And when you fight it, what happens?  
24 It increases heart demand, increases blood  
25 pressure, increases all of those things that you  
26 don't want to see.
- 27 Q Right.
- 28 A And so if we're going to restrain an individual,  
29 we almost always try to also chemically treat that  
30 individual to decrease that level of agitation.
- 31 Q So let me ask you this question. You're in a  
32 hospital setting, and you're in a major hospital  
33 with people of all shapes and sizes coming in.
- 34 A Yes.
- 35 Q And in all manners of distress, physical and in  
36 this area mental, correct?
- 37 A Mm-hmm.
- 38 Q There are occasions when you use physical  
39 restraint but you always do so with a sedating  
40 medicine, I understand you to say.
- 41 A Not always. I mean, for example, if we have a  
42 patient who's just come in, we don't know anything  
43 about and they are highly agitated -- for example,  
44 too much sedation if the patient has a head  
45 injury, a significant head injury and we haven't  
46 diagnosed that head injury, sedation can  
47 potentially lead to serious problems. But by and

Dr. Lu Shaohua (Medical presenter)  
Questions by Mr. Vertlieb (cont'd)

- 1 large, we try to have chemical restraint at the  
2 same time as physical restraint. But again, there  
3 are scenarios when we cannot do that because we  
4 don't know enough about what's happening --
- 5 Q I understand.
- 6 A -- and that judicious use of pharmacology is  
7 necessary.
- 8 Q And so when you have these cases where you use  
9 physical restraint and chemical restraint, are you  
10 having people die on you in the hospital when  
11 that's being done?
- 12 A Not that I have encountered. One of the reasons  
13 for that, I suspect, is because in hospital type  
14 setting, patients have that vulnerability, and in  
15 a way because they have that vulnerability, it  
16 takes less noxious stimuli to get them into a  
17 delirious state, and so they haven't got to this  
18 most severe range. And again, in the hospital  
19 setting, if a patient passes away, we would be  
20 able to attribute that to an underlying medical  
21 condition rather than to the delirium in and of  
22 itself.
- 23 Q So when you have people physically restrained in  
24 the hospital setting used with appropriate  
25 medicine, you are not having people die?
- 26 A Knock on wood, no.
- 27 Q Thank you. I wanted to ask you very briefly, one  
28 of the slides -- and I don't have the page number.  
29 I'll just tell you which slide. You're familiar  
30 with your presentation. It's the near the end.  
31 Mr. Commissioner, if you look --
- 32 THE COMMISSIONER: I don't seem to have that. Go  
33 ahead.
- 34 MR. VERTLIEB: Why would you need to have that, Mr.  
35 Commissioner?
- 36 THE COMMISSIONER: (Laughing)
- 37 MR. VERTLIEB: We'll make sure that that's corrected.
- 38 Q The slide that says vulnerability liability model.
- 39 A Yes.
- 40 Q And it's where you talk about high morbidity,  
41 increases to mortality, and then you say difficult  
42 to diagnose even in a medical setting. The last  
43 point you make is additional insults can lead to  
44 cardiac arrest or sudden death. Do you remember  
45 that point that you made?
- 46 A Yes.
- 47 Q You say in an otherwise healthy individual, sudden

Dr. Lu Shaohua (Medical presenter)  
Questions by Mr. Vertlieb (cont'd)

1 onset of delirium may be a warning sign of a  
2 potentially life-threatening metabolic change.  
3 And then you say an additional insult can lead to  
4 cardiac arrest or sudden death.  
5 A Yes.  
6 Q Would something like a Taser application be such  
7 an additional insult?  
8 A I don't know enough about Tasers, to tell you the  
9 truth, to be able to answer that. But what I can  
10 say is, in an otherwise healthy individual, to get  
11 to the delirious state, an individual likely has  
12 profound exhaustion or electrolyte changes and  
13 they can maintain to that extent, which is they  
14 are at the end of their physical capability before  
15 that delirious state kicks in, and in that state,  
16 whatever additional insult might be, maybe  
17 struggling, fighting, that can lead to the body  
18 just giving out. That can occur. And that's what  
19 I mean by that, cardiac arrest and sudden death.  
20 Q So you're talking about the person who's at such a  
21 state of exhaustion that some additional insult  
22 could be the tipping point --  
23 A Yes.  
24 Q -- that could lead to death?  
25 A Yes. But in terms of whether or not Taser can do  
26 it or not, I don't know.  
27 MR. VERTLIEB: I understand. Thank you very much,  
28 Dr. Lu, for coming here today. Thank you,  
29 Mr. Commissioner.  
30 THE COMMISSIONER: Doctor, I can't help but think about  
31 this. Again, this may be a question that you  
32 can't answer because you don't pretend for a  
33 moment to be an expert on Tasers. But one of the  
34 problems facing the policing authorities is if  
35 someone exhibits the symptoms that you have  
36 described in a street setting and the symptoms are  
37 severe and the man is young - we'll assume it's a  
38 man and that he is young - then you have described  
39 to us how no doubt the underlying problems are  
40 quite severe, just to use neutral terms here for a  
41 minute. And of course you counsel that education  
42 comes first, which means skills in terms of  
43 communication and maybe getting an ambulance to  
44 come and things like that. But would you be able  
45 to say whether or not there could be a state  
46 reached where something as severe as a Taser could  
47 be used?

Dr. Lu Shaohua (Medical presenter)  
Questions by Mr. Vertlieb (cont'd)

1           A     And I will say yes, for a couple of reasons.  
2                     Number one, again, delirium is presented in a  
3                     disorganized, agitated state. I cannot tell --  
4                     for example, let's say if I were to see a patient,  
5                     I don't think I can tell whether or not, in let's  
6                     say a brief two-minutes or 15 seconds, if they  
7                     just have that information -- you know, somebody  
8                     who's really agitated; let's say I drive down the  
9                     street and somebody -- whether or not they're in a  
10                    delirious state, in a severe psychotic state, in a  
11                    drug-induced state. I don't think one can tell.  
12                    And in that case, necessary force to help control  
13                    the situation -- don't forget, if a patient is in  
14                    a delirious state, they can really harm  
15                    themselves, and they can really harm themselves,  
16                    again, not because they mean to but because they  
17                    have become disorganized, run out in traffic and  
18                    other things.

19                    In hospital - again, I can really speak about  
20                    hospital setting - there are times when really,  
21                    it's heart-wrenching for a family to see three  
22                    security guards go in to pile on an elderly  
23                    individual. But you know, sometimes that's the  
24                    only way to have that situation controlled.

25                    And so translating that scenario into the  
26                    community setting, I certainly can see scenarios  
27                    where attempt at communication doesn't work,  
28                    attempt to de-escalate doesn't work, and the  
29                    patient is simply in an agitated state. And in  
30                    that case, weapon use or whatever restraint  
31                    necessary to get the individual in a safe  
32                    environment perhaps is necessary.

33           THE COMMISSIONER: I see. So the insult, as you've  
34                    described it, of the environment that he's in,  
35                    which includes the environment, the police and so  
36                    on, has to be weighed against the little - not  
37                    little - the other insult of the use of the Taser.  
38                    In any event, the external insults will be  
39                    increasing in the mind of such a person.

40           A     Yes.

41           THE COMMISSIONER: All right. Doctor, thank you very  
42                    much for taking the time to come here. It's very  
43                    much appreciated.

44           A     You're welcome.

45           THE COMMISSIONER: All right, ten-minute break.

46  
47

(PRESENTER EXCUSED)

Dr. Michael Webster (Non-medical expert presenter)  
Questions by Mr. McGowan

1 (PROCEEDINGS ADJOURNED)  
2 (PROCEEDINGS RECONVENED)

3

4 THE COMMISSIONER: I believe we can commence. Yes,  
5 counsel.

6 MR. MCGOWAN: We can, Mr. Commissioner. The next  
7 presenter is Dr. Mike Webster. Dr. Webster is a  
8 psychologist and he has some expertise in the  
9 areas of crisis intervention and police  
10 procedures.

11

12 DR. MICHAEL WEBSTER, a Non-  
13 medical expert presenter.

14

15 QUESTIONS BY MR. MCGOWAN:

16

17 Q Dr. Webster, before we send you off on your  
18 presentation, I'm going to spend a few minutes  
19 with you just reviewing your background for the  
20 Commission.

21 A Of course.

22 Q You were born in Victoria?

23 A That's correct.

24 Q And you grew up primarily in the Vancouver area;  
25 is that correct?

26 A I did, that's correct.

27 Q After completing your high school, you headed off  
28 to university, initially to the University of  
29 Notre Dame?

30 A Correct.

31 Q Where you obtained a bachelor of arts majoring in  
32 psychology in 1966?

33 A I did.

34 Q And then you proceeded on to Western Washington  
35 University?

36 A Yes.

37 Q Please tell the Commissioner about the degree you  
38 obtained there.

39 A I obtained my master's degree in psychology there.

40 Q And which area of psychology was that in?

41 A Counselling psychology.

42 Q And you completed that in what year?

43 A I think that was completed in 1973.

44 Q And you subsequently went on to obtain your  
45 doctorate degree in counselling psychology?

46 A At UBC, correct.

47 Q And what year was that?

- 1 A 1980.
- 2 Q Subsequent to your education, you've had quite a  
3 diverse career, I understand.
- 4 A I have, yes.
- 5 Q You've done some work in the prison environment?
- 6 A Yes. I was a psychologist both at the B.C. Pen,  
7 the old B.C. Pen in New Westminster, and at  
8 William Head on Vancouver Island.
- 9 Q And you were dealing with inmates there?
- 10 A That's correct.
- 11 Q You've also had a fair amount of work experience  
12 in the area of addictions; is that correct?
- 13 A I did work for a time, yes, with the British  
14 Columbia Addictions.
- 15 Q Describe your work in that area just briefly.
- 16 A I was a clinician at one of the community clinics.
- 17 Q And through much of your career, I understand,  
18 you've also maintained a private practice?
- 19 A Yes, I have.
- 20 Q Just tell the Commissioner a little bit about that  
21 area of your work.
- 22 A That area of my work began in the mid-1970s after  
23 I had been a psychologist working at the B.C. Pen  
24 and was involved in two of the major hostage-  
25 takings at the Pen. I had assisted the police,  
26 consulted with the RCMP when they attended to  
27 manage those incidents, and I made a connection  
28 with them at that time and became a member of  
29 their members' assistance program, a clinician in  
30 their employee assistance program. And I also  
31 began to consult with them in crisis situations,  
32 hostage-takings, barricaded persons incidents,  
33 kidnappings and incidents of public disorder, that  
34 type of thing.
- 35 Q You also had a private clinical practice where you  
36 saw patients in your counselling psychology area;  
37 is that correct?
- 38 A That's correct. That was the members' assistance  
39 program, the RCMP's employee assistance program.
- 40 Q So your clients were primarily police officers --
- 41 A Correct.
- 42 Q -- or police personnel?
- 43 A Correct.
- 44 Q I understand you also went on at some point in  
45 your career to receive basic police training.
- 46 A I did.
- 47 Q Tell the Commissioner about that.

- 1 A Yes. I had been a psychologist working with the  
2 police for close to 15 years and I thought that I  
3 could make a better contribution from inside the  
4 organization as a member of the RCMP. I had a  
5 particular goal in mind. The RCMP was opening  
6 their ViCLAS section in Ottawa at the time, their  
7 Violent Crime Analysis unit, and they were looking  
8 for criminal investigative analysts. And I  
9 thought with my psychological training and  
10 experience that I would fit well there, so I  
11 entered the RCMP. I went through training. But I  
12 soon found out that I would not be posted to that  
13 type of a position. I was going to be a general  
14 duty policeman. So I quickly lost interest as I  
15 was 43 years of age at the time. I quickly lost  
16 interest and returned to my private practice.
- 17 Q Subsequent to that, however, you have continued to  
18 do work with the police forces in British  
19 Columbia, both the RCMP and municipal forces in  
20 the areas of training and otherwise; is that  
21 correct?
- 22 A I have. I work with police services  
23 internationally, in Europe and South America as  
24 well as here at home in Canada.
- 25 Q And tell us just briefly about your experience in  
26 the area of training.
- 27 A Training police persons?
- 28 Q Yes, training police persons.
- 29 A I for a number of years, since the early 1980s,  
30 have been involved at the Canadian Police College  
31 training police persons in the area of crisis  
32 negotiations and incident command. Presently I'm  
33 involved in instructing with the Organized Crime  
34 section out of Ottawa in the area of national  
35 security.
- 36 Q Do you have experience, Dr. Webster, with the  
37 application of force and how people respond to the  
38 application of force in the police context?
- 39 A I have. I've been in attendance at many, many  
40 kidnappings, many, many hostage-takings,  
41 barricaded persons incidents, incidents of public  
42 disorder, the G8, the G20. I have what I would  
43 consider to be quite extensive experience with the  
44 applications of force and people's responses to  
45 them.
- 46 Q And have those scenarios you've discussed only  
47 been with Canadian police forces or do you also do

1 work with other police forces?

2 A Other polices forces, internationally.

3 Q And those include the FBI?

4 A I work closely with the FBI, and Europol, South  
5 American police agencies, largely in Colombia.  
6 I've been in Peru, Iceland, Australia.

7 Q Thank you, Dr. Webster. And perhaps just before  
8 we finish up with your introduction, you could  
9 tell the Commissioner what it is you're doing  
10 today. What does your practice look like today?

11 A My practice today is focused more on the area of  
12 national security than it is in the area of crisis  
13 intervention. Since September the 11th, 2001, the  
14 RCMP have placed an additional emphasis on the  
15 gathering of intelligence to assist them in  
16 national security matters, and I provide  
17 consultation in that area as well.

18 Q And are you still involved in providing training  
19 or assisting with training?

20 A I am.

21 MR. MCGOWAN: Thank you, Dr. Webster. I think at this  
22 point I'll invite you to commence your  
23 presentation to the Commissioner.

24 A Okay, I will.

25

26 PRESENTATION BY DR. WEBSTER:

27

28 A As I'm somewhat technologically impaired, I will  
29 just read you my presentation.

30 Mr. Commissioner, police patrol personnel  
31 during the course of their work are often faced  
32 with individuals exhibiting some of the following  
33 characteristics: bizarre and/or aggressive  
34 behaviours, shouting, elevated suspicion, anxiety  
35 or panic, violence, unexpected physical strength,  
36 profuse sweating.

37 In a growing number of cases, they appear to  
38 be reaching for their Tasers to assist them in  
39 gaining control of the uncooperative individual.  
40 In some of these cases, especially some of those  
41 resulting in death, the circumstances under which  
42 the weapon is deployed seem suspect even to the  
43 untrained eye.

44 I will look at the weapon from the  
45 perspective of a police psychologist. The  
46 appropriate use of the Taser cannot be addressed  
47 without a discussion of the controversial

1 phenomenon, excited delirium. The police, in an  
2 attempt to justify their use of the weapon, in  
3 many cases have taken to citing this hypothetical  
4 disorder.

5 Opinion as to its validity falls on both  
6 sides of the issue. Some argue that the condition  
7 is not only valid but responsible for a large  
8 majority of in-custody deaths, including those in  
9 which the deceased has been stunned with a Taser.

10 On the other side, it is noted with great  
11 concern that no reputable medical, psychiatric or  
12 psychological association recognizes excited  
13 delirium as a medical or mental health condition.  
14 Nearly all cases of the phenomenon involve people  
15 fighting with or being restrained by the police.

16 Even with an extensive autopsy, there is no  
17 definitive way to prove that someone died of  
18 excited delirium. And it may be that police and  
19 medical examiners are using the term as a  
20 convenient excuse for what could be excessive use  
21 of force or inappropriate control techniques  
22 during an arrest.

23 My own opinion on this is that Canadian law  
24 enforcement and its American brothers and sisters  
25 have been brainwashed by companies like TASER  
26 International and the Institute for the Prevention  
27 of In-Custody Deaths. These companies have  
28 identified a need within police work and created a  
29 product that basically sells itself. How can you  
30 argue against something that purports to save  
31 life? Moreover, these organizations have created  
32 a virtual world replete with avatars that wander  
33 about with the potential to manifest a horrific  
34 condition characterized by profuse sweating,  
35 superhuman strength and a penchant for smashing  
36 glass that appeals to well-meaning but  
37 psychologically unsophisticated police personnel.

38 The phenomenon of excited delirium has been  
39 of great assistance to TASER International in the  
40 recent past. The company has successfully  
41 defended itself against at least eight lawsuits in  
42 which it was alleged that the victims died of  
43 Taser shocks. The company argued that the cause  
44 of death was excited delirium and not the Taser.  
45 TASER International spokesman Steve Tuttle has  
46 acknowledged that the company sends thousands of  
47 pamphlets to medical examiners explaining how to

1 detect excited delirium. The company also holds  
2 training seminars around the North American  
3 continent attended by thousands of law enforcement  
4 personnel, including Canadians.

5 TASER International makes a concerted effort  
6 to educate both the law enforcement and medical  
7 communities with regard to excited delirium.

8 TASER International business associate John Peters  
9 heads up a company called the Institute for the  
10 Prevention of In-Custody Deaths. It specializes  
11 in training police persons, coroners, emergency  
12 room physicians and other medical professionals in  
13 sudden death from excited delirium. Mr. Peters is  
14 also one of TASER International's star witnesses  
15 when the company has to defend itself in court  
16 against charges that its weapon has killed. In  
17 addition, he and his company have been on TASER  
18 International's payroll to provide instruction at  
19 their training academy.

20 TASER International and the Institute for the  
21 Prevention of In-Custody Deaths, complete with  
22 supportive physicians and researchers, all on the  
23 payroll, have through a brilliant marketing scheme  
24 created an extremely lucrative business built  
25 largely on a dubious disorder.

26 In my opinion, these two companies have  
27 revitalized an old and mythical condition and  
28 influenced law enforcement's conceptions of crisis  
29 and its management. Genuinely motivated Canadian  
30 police persons have, in an attempt to manage  
31 crises, explain the tragedy of in-custody deaths  
32 and ridiculously inappropriate applications of the  
33 Taser, embraced the controversial concept of  
34 excited delirium. It is these misperceptions that  
35 have influenced police persons to deploy the Taser  
36 in some situations that fall well outside the  
37 acceptable usage scenarios provided for in policy.

38 Canadian law enforcement's own National Use  
39 of Force Framework states that an officer's  
40 perception is his or her reality. In other words,  
41 if every person in crisis is perceived as  
42 experiencing this unmanageable and non-responsive  
43 condition and the only way to handle it is with a  
44 Taser, then the Taser will be deployed. When you  
45 think the only tool you have is a hammer, then the  
46 whole world begins to look like a nail.

47 As perception lies at the heart of the

1 Canadian Use of Force Framework, we need to be  
2 more critical of what or who influences the  
3 perceptions of our police services. Physicians,  
4 psychiatrists and psychologists working in  
5 hospital emergency rooms and psychiatric emergency  
6 services readily relate how individuals who are  
7 exhibiting the symptoms of hyperarousal can be  
8 managed in a variety of ways ranging from  
9 medication to communication. Staff is trained to  
10 handle agitated patients by speaking in calm, non-  
11 confrontational tones and adopting neutral body  
12 postures.

13 Excited delirium does not appear in the  
14 Diagnostic and Statistical Manual of Mental  
15 Disorders. As Dr. Lu pointed out for us this  
16 morning, plain old delirium does. It can be  
17 brought on as a direct physiological consequence  
18 of a general medical condition, substance abuse,  
19 intoxication or withdrawal, use of a medication,  
20 exposure to a toxin, stress, or a combination of  
21 these factors.

22 Mr. Frank Lasser, the 82-year-old man  
23 hospitalized in Kamloops, who received several  
24 jolts from an RCMP Taser last week, may be an  
25 example of a case of delirium brought on by a  
26 general medical condition. He was in hospital  
27 fighting pneumonia.

28 Delirium can be of the active variety and  
29 resemble the behaviour of Robert Dziekanski, or it  
30 can be of the less active variety where people  
31 become muted and withdrawn. Properly trained  
32 mental health professionals are aware that the  
33 more active variety increases the risks associated  
34 with physical restraints. Death from delirium is  
35 extremely rare.

36 Determining the cause of death of someone who  
37 was suffering from delirium is always a challenge.  
38 Was it the disorder, the restraint, the Taser, or  
39 a complex interplay of all the foregoing? In my  
40 opinion, well-meaning police services are creating  
41 a potentially libellous situation for themselves  
42 by recognizing the convenient fiction of excited  
43 delirium as a medical condition with symptoms that  
44 include common street behaviours. They are  
45 forcing a higher standard of diagnostic acuity and  
46 standard of care upon themselves for which they  
47 are neither trained to make or manage. Moreover,

1 they provide the basis for a charge of legal  
2 negligence if they fail to provide a standard of  
3 care for a person who dies in their custody and  
4 had exhibited one or more of the published  
5 symptoms of excited delirium, as in the case of  
6 Robert Dziekanski.

7 There is a way to avoid all of this. There  
8 is an alternate view of the symptom picture that  
9 TASER International describes as excited delirium  
10 and an alternate method of management. Most  
11 medical and mental health professionals would  
12 agree that people manifesting this symptom picture  
13 are in a state of hyperarousal. That is, they are  
14 in crisis. They are experiencing a temporary  
15 state of disorganization in which they are unable  
16 to cope with an immediately stressful situation  
17 using their day-to-day coping mechanisms. In  
18 these states, people are affected on several  
19 levels. Cognitively, their ability to process  
20 information is disrupted and disorganized. They  
21 don't use good judgment, they don't make good  
22 decisions, and they're not very good problem  
23 solvers. Their emotions are labile and their  
24 behaviour is random and unpredictable. It is  
25 neither humane nor logical to inflict crippling  
26 pain upon someone who has lost his mental balance.

27 Crisis intervention is designed to assist  
28 people in lowering their arousal level and  
29 regaining their mental balance, enabling them to  
30 use better judgment, make decisions and become  
31 better problem solvers.

32 There are several well accepted ways that  
33 this can be accomplished. The one most amenable  
34 to police first responders is the creation of a  
35 safe, non-threatening environment. The first rule  
36 of crisis intervention is: no more crisis.  
37 During a review of Taser tragedies, it is not  
38 difficult to see numerous violations of this rule.  
39 This type of training is not offered routinely by  
40 all police training academies nor as an in-service  
41 course in Canada. Locally it is provided by the  
42 Vancouver Police Department to its patrol  
43 personnel. It is my understanding that the RCMP,  
44 following the death of Robert Dziekanski, has  
45 undertaken this type of training in the Lower  
46 Mainland.

47 The training usually entails five to seven

1 days and covers a broad array of topics, including  
2 drug awareness, mental health issues, conflict and  
3 crisis theory, crisis intervention, verbal and  
4 non-verbal communication techniques, and  
5 experiential exercises.

6 It is my recommendation that, if the Taser  
7 proves to be safe, its use in Canada be restricted  
8 to only those situations involving a significant  
9 risk of death or grievous bodily harm and that  
10 Canadian law enforcement be provided with crisis  
11 intervention training during their basic police  
12 training.

13 Thank you, Mr. Commissioner. I'll conclude  
14 there.

15 THE COMMISSIONER: Thank you very much, sir. Does  
16 counsel have any comments or questions?

17 MR. MCGOWAN: Mr. Commissioner, we will have a few  
18 questions. I wonder if we might have just a  
19 couple of minutes to consult.

20 THE COMMISSIONER: Yes, indeed. Five minutes.

21  
22 (PRESENTER STOOD DOWN)

23  
24 (PROCEEDINGS ADJOURNED)

25 (PROCEEDINGS RECONVENED)

26  
27 THE COMMISSIONER: I believe we can commence. Yes,  
28 counsel.

29  
30 DR. MICHAEL WEBSTER, a Non-  
31 medical expert presenter,  
32 resumed.

33  
34 MR. MCGOWAN: Thank you, Mr. Commissioner.

35  
36 QUESTIONS BY MR. MCGOWAN, continuing:

37  
38 Q Dr. Webster, thank you for your presentation. I  
39 just have a few questions to clarify a few matters  
40 and perhaps get a little more helpful information  
41 for the Commission.

42 You told us of this crisis intervention  
43 training, and you're personally involved in  
44 delivering this training to police forces?

45 A I am.

46 Q Which police forces in British Columbia have you  
47 been involved in delivering this training to?

- 1 A To my knowledge, there's only one and I'm involved  
2 with that one, and that's the Vancouver Police  
3 Department. Now I understand the RCMP has  
4 undertaken this since the death of Robert  
5 Dziekanski.
- 6 Q And how long have you been involved in providing  
7 the crisis intervention training to the Vancouver  
8 Police Department?
- 9 A It's a week long course and there are other people  
10 who come to visit them, other instructors. I play  
11 a small part in that. I've been doing it since --  
12 I think they began in 2001, around that time.
- 13 Q Have you been approached by any other police  
14 forces in British Columbia and asked to be  
15 involved in similar training?
- 16 A I have not. But they wouldn't approach me to  
17 organize the thing. It would be something that  
18 they would organize on their own, and again, I  
19 would come and provide that small psychological  
20 communication component.
- 21 Q Tell us a little bit about the course, Dr.  
22 Webster. How long does it run? How long do we  
23 have a police officer out of service on the street  
24 to attend this course?
- 25 A A week.
- 26 Q And in your view, is that sufficient time?
- 27 A It is. If the time is used judiciously and there  
28 is an active component to the training, that is  
29 they get an opportunity to actually try on the  
30 skills and practise them rather than just sit and  
31 talk about them, yes, it is.
- 32 Q What specific skills are taught in the crisis  
33 intervention training course?
- 34 A There's a lot of theory presented in the area of  
35 drugs and mental health, crisis and conflict. The  
36 specific skills taught are communication skills.  
37 In general they would be the non-confrontational,  
38 speaking to people in calm, non-confrontational  
39 tones and adopting neutral body postures. There's  
40 non-verbal communication techniques that are  
41 offered to address those situations, like where  
42 Mr. Dziekanski couldn't speak English so we need  
43 to use some other means of communicating with him.  
44 And then they have an opportunity to engage in  
45 some experiential exercises and actually apply the  
46 skills.
- 47 Q You told us in your presentation about some of the

1 aspects of crisis intervention that you think are  
2 important. You spoke of creating a safe  
3 environment and encouraging officers to adopt a  
4 neutral body posture.

5 A Mm-hmm.

6 Q Could you tell the Commissioner a little bit more  
7 about that, please.

8 A Well, there are several ways that you could deal  
9 with a person in crisis. You can mitigate them,  
10 you can hospitalize them, you could get them  
11 involved in some sort of outpatient therapy. But  
12 those are not really appropriate to a street  
13 police person. There's one way left that is very  
14 appropriate to the street police person and that  
15 is the creation of a safe, non-threatening  
16 environment. If we can do that, now what happens  
17 is that individuals tend to regain their mental  
18 balance. They tend to regain their ability to use  
19 good judgment - use better judgment - to make some  
20 decent decisions and to assist the police person  
21 in solving whatever the immediate problem happens  
22 to be.

23 The crucial thing is no more crisis. You  
24 can't expect a person who is hyperaroused, their  
25 cognitive process is disrupted and disorganized,  
26 you can't expect them to contend with commands or  
27 even wonderful solutions to whatever the present  
28 problem is. Those are going to go right over  
29 their heads until we get that arousal level down.  
30 So the whole skill package, the whole  
31 communication technique package, is designed to  
32 bring the arousal level down so now we can begin  
33 to do some problem-solving.

34 Q What about the neutral body posture? What would  
35 that look like?

36 A A neutral body posture for Dr. Lu in the hospital  
37 would be very different than the neutral body  
38 posture for a street police person. A street  
39 police person has to take into consideration  
40 officer safety. Therefore it will be somewhat  
41 modified. But you can imagine in the hospital you  
42 would face a person straight on and you would  
43 perhaps have your hands at your sides or you may  
44 clasp them in front of you like this (gesturing).  
45 You look like a non-threatening person. A police  
46 person -- police people because they're wearing  
47 weapons often like to blade themselves, turn

1 themselves away from the people -- to get their  
2 weapon, put themselves between their weapon and  
3 the person they're dealing with. So there's some  
4 modification of these things on the street, but it  
5 can still be done.

6 Q Do you see or are you familiar with settings where  
7 the skills taught in the crisis intervention  
8 training are put into practice and have been  
9 effective?

10 A Yes, I have. I had occasion just two weeks ago to  
11 visit three of the B.C. Corrections Branch centres  
12 here in British Columbia, and you have corrections  
13 officers in these centres who are dealing with  
14 belligerent, combative, uncooperative, threatening  
15 individuals all day long, and they are not armed.  
16 Yes, they have access to a Taser but the Taser is  
17 in a weapons locker way back in the bowels of the  
18 institution somewhere. They have to deal with  
19 these situations on a constant basis, and they  
20 manage to do it.

21 Q Dr. Webster, during your presentation you made  
22 reference to, I think it was the Institute for the  
23 Prevention of In-Custody Deaths?

24 A Yes.

25 Q We heard about that for the first time the other  
26 day and it's been mentioned by you again. What  
27 can you tell us about that institute?

28 A I can tell you that they've -- again, this is a  
29 company, and I must admire their entrepreneurial  
30 spirit. They've identified a need within the law  
31 enforcement community, and this need now is --  
32 it's distasteful to the community to see people  
33 die in the custody of the police. The police are  
34 given the job now when someone is put in their  
35 custody -- they take someone into their custody,  
36 they have to ensure their safety and their  
37 survival. When someone dies, the community  
38 doesn't like that. The institute has come along  
39 now and they have focused on this particular area  
40 and they go about the country teaching police  
41 services how to prevent in-custody deaths. The  
42 one thing that they seem to spend a lot of time on  
43 is educating police personnel and medical  
44 personnel about excited delirium, and they teach,  
45 or have taught - I don't know if they still do; I  
46 must be fair to them - they have taught at TASER's  
47 training academy, and Mr. Peters, the president of

1 the institute, often appears -- when TASER is on  
2 trial trying to defend their weapon, he will often  
3 appear to support TASER and excited delirium.

4 Q Now, I take it there are circumstances where the  
5 crisis intervention techniques aren't effective.  
6 They just don't get through.

7 A Yes.

8 Q What do you suggest to police officers in those  
9 circumstances?

10 A Well, I think it's important to consider the Use  
11 of Force Framework. At the centre of the Use of  
12 Force Framework that all police services in Canada  
13 subscribe to, there is the officer's perception  
14 and the component -- they call it assess, plan,  
15 act. So police persons are supposed to be  
16 continually assessing the situation that they are  
17 in. They need to have a variety of skills that  
18 they can use to apply to whatever the assessment  
19 is that they make of the particular situation. Of  
20 course, if communicating with someone, attempting  
21 to bring someone's arousal level down, is not  
22 going to be effective, then they need to have the  
23 freedom or the option to escalate to a different  
24 option of force. And before you get to  
25 intermediate weapons in the framework, there are  
26 soft hand techniques and hard hand techniques that  
27 could be used. And if none of those are  
28 effective, then one could graduate to intermediate  
29 weapons. And of course, if an intermediate weapon  
30 isn't going to do the job, then lethal force.

31 But the key for me, the issue for me is that  
32 police persons need to have realistic perceptions.  
33 They need to understand -- I'm not suggesting that  
34 they need to go step by step by step; they need to  
35 first appear, then verbally interact with the  
36 subject and then try soft hand and then try hard  
37 hand and then go to intermediate. I'm not  
38 suggesting that because sometimes situations can  
39 escalate quite quickly and you don't have an  
40 opportunity to go through all of those and you  
41 need to protect yourself or protect the public.

42 But what I am suggesting is that I think they  
43 have some misperceptions and they are too quick to  
44 jump to the use of a conducted energy weapon,  
45 thinking that this individual is suffering from  
46 this horrific disorder and there's no other way to  
47 deal with him than to apply my Taser.

- 1 Q You're not against the use of the Taser in  
2 principle? Am I right about that?
- 3 A No, I think there's a place for the Taser.
- 4 Q In your view, what is that place on the use of  
5 force continuum?
- 6 A Well, that would be the last thing before you have  
7 to shoot somebody. If there is a threat to life  
8 or grievous bodily harm and you can avoid shooting  
9 someone by using a Taser, then I would agree with  
10 the use of a Taser.
- 11 Q Dr. Webster, we've had some medical and scientific  
12 experts here talking about the Taser itself and  
13 the safety of the Taser, and we'll have some more.  
14 And I take it you're not an expert and don't offer  
15 an opinion on the safety of the device itself?
- 16 A I'm not an expert and I don't have an opinion on  
17 the safety of it.
- 18 Q Now, given your psychological background, I wonder  
19 if you're able to help the Commission with an  
20 opinion on whether there's a potential for lasting  
21 psychological effects from being Tasered to  
22 somebody with a mental illness, say for example.
- 23 A Yes. Yes, I think there is a potential for  
24 someone to have a chronic response to being the  
25 victim of a Taser. That would depend upon how now  
26 the victim views the incident of being Tasered.  
27 If a victim views this as a life-threatening  
28 event, if they in going through their convulsions  
29 and what not as they're being pulsed with the  
30 Taser, they view this as they could lose their  
31 lives, then yeah, this could go through -- I'm  
32 sure they would have an acute anxiety response  
33 immediately thereafter, and if that's not  
34 resolved, this could graduate into a more chronic  
35 post-traumatic response.
- 36 Q Thank you. Dr. Webster, during your presentation  
37 you were critical of police forces for taking  
38 their information directly from the manufacturer  
39 about excited delirium and about circumstances  
40 when it may or may not be appropriate to use a  
41 Taser and when it may or may not be the best  
42 option. Where do you say they should be getting  
43 their information from? What sort of a framework  
44 would you like to see?
- 45 A Well, I would like us as a country to take a look  
46 at conducted energy weapons and their safety and  
47 where and when they should be applied. I don't

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1 think we should swallow this whole hog from south  
2 of the border. Some of these incidents that we  
3 see in the media of people being Tasered are  
4 frankly embarrassing. This is not the best of  
5 Canadian policing. This is not what we as  
6 Canadians would like our police services -- how we  
7 would like our police services to behave.

8 Q And just finally, Dr. Webster, what's your  
9 motivation for being here today and sharing your  
10 thoughts with us? What's underlying your concern  
11 and what's the reason you've come here today?

12 A I'm not anti-police. I've worked with the police  
13 for over 30 years, and as I said a moment ago, I'm  
14 embarrassed to be associated with organizations  
15 that Taser sick old men in hospital beds and  
16 confused individuals, immigrants arriving to the  
17 country. Frankly I find it embarrassing. And  
18 again, it's not the best of Canadian policing. I  
19 don't think it's what we as Canadians want our  
20 police services to look like.

21 Q Do you have anything else which you wish to add,  
22 Dr. Webster?

23 A I don't think so, no.

24 THE COMMISSIONER: Dr. Webster, thank you very much for  
25 taking the trouble and the time to both prepare  
26 your presentation and to come here. Thank you so  
27 much.

28 A Thank you, Mr. Commissioner.

29  
30 (PRESENTER EXCUSED)

31

32 MR. MCGOWAN: Mr. Commissioner, we have one more brief  
33 witness this morning. He's an interested member  
34 of the community, Mr. Errol Povah.

35  
36 ERROL POVAH, an Interested  
37 groups and individuals  
38 presenter.

39

40 THE COMMISSIONER: Yes. Welcome, sir.

41 A Thank you. Good morning, Mr. Commissioner and  
42 counsel.

43 MR. MCGOWAN: Thank you, Mr. Povah.

44 THE COMMISSIONER: How do we spell Mr. Kovah's name?  
45 K-O --

46 MR. MCGOWAN: It's with a P, Mr. Commissioner. I  
47 believe it's P-O-V-A-H.

Errol Povah (Interested groups and individuals presenter)

Questions by Mr. McGowan

1 A That's correct.

2 THE COMMISSIONER: Thank you.

3 MR. MCGOWAN: Now, Mr. Povah, as we've done with all of  
4 our presenters, I'm going to spend just a couple  
5 of minutes asking you about yourself before we get  
6 started.

7 A Okay.

8

9 QUESTIONS BY MR. MCGOWAN:

10

11 Q You grew up -- tell the Commissioner where you  
12 grew up.

13 A I was born and raised in Nanaimo, moved over to  
14 the mainland about 15 years ago with my job.

15 Q And you finished your high school and did a brief  
16 stint at a post-secondary institution?

17 A That's correct.

18 Q Following which you entered the Navy and spent  
19 three and a half years there?

20 A Yes.

21 Q And what were you doing in the Navy?

22 A I was a radioman.

23 Q And that was the Canadian Navy?

24 A That's correct.

25 Q And what sort of training did you receive in the  
26 navy connected with your radio operations?

27 A Well, in addition to military basic training in  
28 Cornwallis, Nova Scotia, yeah, there was sea  
29 environmental training just for those who had not  
30 been to sea. Again, just very basic preparation  
31 for life at sea and specifically in the Navy,  
32 radio operating training, et cetera.

33 Q Thank you. And after the Navy you entered the  
34 realm of B.C. Ferries, where you've served as a  
35 deck hand and a second officer, I understand, for  
36 the last 31 years?

37 A That's correct.

38 Q And are you still employed by B.C. Ferries or have  
39 you retired?

40 A I am still employed.

41 Q In addition to your work, you are a committed and  
42 quite an involved activist; is that correct?

43 A That's correct.

44 Q And that's in the area of the anti-tobacco lobby;  
45 is that correct?

46 A That's certainly one of my main interests. I'm  
47 involved in a number of other things as well. I'm

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1 a member of Sea Shepherd Conservation Society.

2 I've been involved in some deportation cases.

3 Q So you're a B.C. Ferries employee and part-time  
4 lobbyist. Is that fair to say?

5 A I consider myself more a full-time activist and a  
6 part-time ferry worker, even though it is full  
7 time.

8 Q Fair enough. And just to be clear so that we all  
9 understand where you're coming from, you don't  
10 have technical or electrical training?

11 A That's correct, none whatsoever.

12 Q And you're not an expert in Taser use or policing  
13 matters?

14 A Not at all.

15 Q You're here as an interested member of the  
16 community to share your thoughts with the  
17 Commissioner?

18 A A concerned citizen.

19 Q Okay.

20 A Absolutely.

21 MR. MCGOWAN: I'm going to invite you now, Mr. Povah,  
22 to spend a few minutes and tell the Commissioner  
23 about your perspective.

24

25 PRESENTATION BY MR. POVAH:

26

27 A Okay. Thank you. I'm here today to contribute my  
28 two bits' worth to the Taser discussion. On at  
29 least a dozen occasions over the last couple of  
30 years, I have very publicly, via published letters  
31 to the editor, calls to radio talk shows, et  
32 cetera, raised the question: Is it 50,000 volts  
33 or nothing? It seems that no one can or will  
34 answer that question, and I find that extremely  
35 frustrating. I'm hopeful that by the end of this  
36 public inquiry, I will have a satisfactory answer  
37 to that very simple question.

38 I'm not an electrician by any stretch of the  
39 imagination. In fact I sometimes find changing  
40 light bulbs a major challenge. That said, it's my  
41 understanding that what actually does the harm in  
42 electricity has much more to do with the amperage  
43 or wattage or the ohms or whatever, something  
44 other than the voltage. Well, if that's the case,  
45 why is it that virtually every time we hear about  
46 Tasers, we also hear about 50,000 volts? In fact  
47 just last night on the news I heard Cameron Ward

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1           once again make reference to 50,000 volts. And on  
2           that same newscast I heard Ujjal Dosanjh express  
3           regret about approving the Taser in B.C. when he  
4           was attorney general, and I guess I just hope that  
5           he's not -- he suggested that he sort of rushed to  
6           that decision or it was somewhat of a knee-jerk  
7           decision. I'm hoping that he doesn't -- or no one  
8           else in a similar position rejects Tasers and  
9           outlaws them in a similar fashion.

10           If voltage is a factor, can it not be turned  
11           down a notch or two, i.e. to 40,000 or 30,000  
12           volts? Or if something else, the amperage et  
13           cetera needs to be turned down a bit, then just do  
14           it. As is the case with the above-mentioned light  
15           bulbs, could Tasers not be fitted with something  
16           that resembles a dimmer switch? Depending on the  
17           circumstances in each and every case that it's  
18           used - and yes, I'm very well aware of the split  
19           second decision aspect in many situations - could  
20           the Taser not be set at a reasonably low level,  
21           and if that doesn't work, then simply crank it up  
22           a notch or two until it does have the desired  
23           effect?

24           Maybe I'm a little naïve but it seems to me  
25           that with a little bit of fine tuning the Taser  
26           could much more safely do the job that it was  
27           originally intended to do. Perhaps Taser deaths  
28           will never be completely eliminated, but it seems  
29           to me that if my idea is at all feasible, there  
30           would be dramatically fewer deaths.

31           In closing I ask again: Is it 50,000 voltage  
32           or nothing? Thank you.

33           That was my original presentation. A couple  
34           of weeks later I received a call from someone with  
35           the Commission who thanked me for the above  
36           submission and suggested I might also be  
37           interested in commenting further on Taser use,  
38           specifically who should use it, under what  
39           circumstances, et cetera. Thus the following.

40           Further to my previous submission re 50,000  
41           volts or nothing and dimmer switches, I'd like to  
42           address the issue of Taser use, specifically my  
43           opinion of Tasers, who should be able to use them  
44           and under what circumstances, bearing in mind of  
45           course that I have absolutely no expertise on the  
46           subject whatsoever. I'm not a doctor. I'm not a  
47           scientist. I'm very much a layperson but one who

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1 has some strong opinions and some good ideas, I  
2 believe, on the matter.

3 Personally I believe Tasers are an extremely  
4 good, very useful and valuable tool, given both  
5 the extremely limited number of weapons options  
6 available to the average general duty police  
7 officer and other law enforcement or peace  
8 officers, such as hand-to-hand combat, batons and  
9 side arms, and conversely, the literally infinite  
10 number of weapons, legal and illegal, available to  
11 the bad guys. I urge anyone who opposes Tasers,  
12 even after taking into account my dimmer switch  
13 idea, to tour the Vancouver Police Museum and  
14 possibly any other facilities with similar  
15 displays. I recently did the tour and was  
16 absolutely mortified by some of the weapons that  
17 police had found and confiscated. The weapons  
18 ranged from crude to very sophisticated, hand made  
19 to machine made. Of all of them, the one that  
20 stood out most in my mind was an otherwise very  
21 basic and simple baseball bat with a couple of  
22 dozen four- or five-inch nails driven through the  
23 business end of it at every angle. Apparently the  
24 deadlier-than-usual baseball bat had been created  
25 by a high school student who brought it to school  
26 to show his buddies, one of whom was sufficiently  
27 concerned that he reported it, police were called,  
28 and it was confiscated before it had an  
29 opportunity to maim or kill anyone.

30 I can't think of a better example of the need  
31 for Tasers, a tool which I believe is a happy  
32 medium between the obviously limited-use baton and  
33 the much deadlier side arm.

34 Addressing the issue of who should use  
35 Tasers, while it may not be feasible financially  
36 or otherwise to provide a Taser for each and every  
37 individual police or peace officer, I believe  
38 Tasers should be readily available for the RCMP,  
39 municipal police forces, sheriffs, deputies,  
40 prison guards, border guards, armoured car  
41 personnel, and possibly, as I just heard on the  
42 news on the way to this inquiry this morning, park  
43 rangers, wardens, and of course B.C. Ferry  
44 workers. I'm kidding about the last one there.

45 The above list may not be complete, and my  
46 apologies to those I may have missed. But my  
47 point is I believe that all those individuals/

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1 organizations that are currently authorized or  
2 licensed to carry side arms in the line of duty  
3 should also have access to Tasers.

4 As far as when the Taser should be used, I  
5 tend to agree with those who have suggested that  
6 at least in some instances police have been far  
7 too quick to deploy the Taser, and also they have  
8 used it in situations in which the suspect was not  
9 at all combative - perhaps angry, agitated,  
10 frustrated, et cetera, but not combative per se -  
11 and posed little or no risk of bodily harm or  
12 death to himself, to anyone else around him or to  
13 the police. The best way to resolve that problem,  
14 better training and, as with any other policy  
15 violation, severe disciplinary action.

16 In closing, if I may, I'd like to say a few  
17 words about the Dziekanski case. Specifically,  
18 the whole Taser issue aside, and at the risk of  
19 sounding extremely self-serving, I strongly  
20 believe that Robert Dziekanski would be alive  
21 today if all international airlines and airports,  
22 along with a great deal of publicity and signage,  
23 made various nicotine replacement therapies -  
24 nicotine gum, inhalers, patches, nicotine water,  
25 et cetera - much more readily available. It's my  
26 understanding he was a heavy smoker and that  
27 perhaps his need for a hit of nicotine contributed  
28 to his high anxiety and stress.

29 Perhaps there is some quick and easy  
30 explanation as to why my dimmer switch idea can't  
31 or won't work, but until I hear it, I think this  
32 is one of those "holy smoke, why didn't I think of  
33 that" ideas.

34 And finally, batons, if misused, can kill.  
35 So can police officers' fists or boots. Should we  
36 take those away from police too? Let's not  
37 further handcuff the police. Pardon the pun.

38 MR. MCGOWAN: Thank you, Mr. Povah. Have you had a  
39 chance to express the thoughts you have on your  
40 mind to your satisfaction?

41 A I have.

42 THE COMMISSIONER: Well, sir, thank you very much for  
43 taking the trouble of preparing that and coming  
44 forward. Thank you so much.

45 A Thank you. Thank you, Mr. Commissioner.

46 MR. MCGOWAN: I have no further questions for Mr.  
47 Povah.

1 (PRESENTER EXCUSED)  
2

3 THE COMMISSIONER: All right. Now, we perhaps  
4 hopefully thought there might be something for  
5 this afternoon.

6 MR. VERTLIEB: We thought so, Mr. Commissioner. We  
7 were hoping to have a presentation from the  
8 Greater Vancouver Transportation Authority Police  
9 Service, and we mentioned that yesterday. But  
10 unfortunately, they are respectfully declining the  
11 opportunity to personally appear before your  
12 inquiry. And so we have no further presentation  
13 material for you today.

14 THE COMMISSIONER: Well, part of this process is to  
15 promote public trust in the policing process and  
16 also, of course, to educate me and the public on  
17 the problems facing these authorities. So that  
18 refusal is indeed disappointing. I'd like to make  
19 it clear, though, that the invitation stands.

20 MR. VERTLIEB: Thank you, sir. We have made that clear  
21 and we will continue to do so. Thank you, Mr.  
22 Commissioner.

23 THE COMMISSIONER: And tomorrow, sir?

24 MR. VERTLIEB: Tomorrow we plan to start at 10:00 a.m.  
25 Perhaps we can just tell you briefly who we expect  
26 to have before you. Mr. McGowan.

27 MR. MCGOWAN: Yes, Mr. Commissioner. Tomorrow we have  
28 the presentation on behalf of the B.C. Municipal  
29 Chiefs of Police and they will be bringing  
30 multiple members. There will be a primary  
31 presentation and then some smaller portions  
32 handled by other presenters.

33 We have a concerned member of the community,  
34 Mr. Jay Page. And in the afternoon we'll be  
35 hearing from Staff Superintendent Mike Federico of  
36 the Toronto Police Service.

37 THE COMMISSIONER: All right. We've got a full day.  
38 Thank you very much. All right, tomorrow at  
39 10:00.

40  
41 (PROCEEDINGS ADJOURNED TO MAY 14, 2008, AT  
42 10:00 A.M.)  
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