



Office of
The Chief
Coroner

Bureau du
coroner
en chef

Q2005-19

AS

Verdict of Coroner's Jury Verdict du jury du coroner

We the undersigned / Nous soussigné

<u>Patrick Abrahams</u>	of / de	<u>Toronto</u>
<u>Heather Dickson</u>	of / de	<u>Toronto</u>
<u>Leck T Jurczyk</u>	of / de	<u>Toronto</u>
<u>Mary Lecour</u>	of / de	<u>Toronto</u>
<u>Joseph Martino</u>	of / de	<u>Toronto</u>

the jury serving on the inquest into the death of / dûment assermentés, formant le jury dans l'enquête sur le décès de:

Surname / Nom de famille Blentzas	Given names / Prénom Nicholas
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aged **24** held at the Coroner's Inquest Courts, Toronto, Ontario
 âgé(e) de qui a été menée à

from the **March 02** to the **March 15** 20 **05**
 du a la

By / Par Dr. **James N. Edwards, M.D.** Coroner for Ontario / coroner pour l'Ontario

having been duly sworn, have inquired into and determined the following: / avons enquêté et avons déterminé ce qui suit:

- | | |
|---|--|
| 1. Name of deceased / Nom du (de la) défunt(e) | Nicholas Blentzas |
| 2. Date and time of death / Date et heure du décès | June 23, 2002 at 2:20am |
| 3. Place of Death / Lieu de décès | Toronto East General Hospital |
| 4. Cause of death / Cause du décès | "Excited Delirium/Restraint Asphyxia associated with an underlying psychiatric illness" |
| 5. By what means / Circonstances entourant le décès | Accidental |

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

The verdict was received on the **15** day of **March** 20 **05**
 Ce verdict a été reçu par moi le

Original signed by Coroner

Distribution: Original - Regional coroner for forwarding to Chief Coroner / L'original - coroner de la région pour transmission au coroner en chef
 Copy - Crown Attorney / Copie - Procureur de la Couronne

Blentzas Inquest.

JURY RECOMMENDATIONS

These Recommendations are not necessarily in order of priority.

1. ***That the Chief of Police of the Toronto Police Service and Toronto Police Services Board:***
 - (i) ***Enhance and continue to ensure that new recruits are taught:***
 - (a) ***The signs and symptoms of excited delirium;***
 - (b) ***That excited delirium constitutes a medical emergency; and***
 - (c) ***The risks associated with the physical restraint of persons experiencing an episode of excited delirium.***
 - (ii) ***Enhance and continue to ensure that all police officers and court officers receive a yearly refresher, during their training on oleoresin capsicum (pepper spray), emphasizing:***
 - (a) ***The signs and symptoms of excited delirium;***
 - (b) ***That excited delirium constitutes a medical emergency; and***
 - (c) ***The risks associated with the physical restraint of persons experiencing an episode of excited delirium.***

RATIONALE:

The evidence presented at this inquiry overwhelmingly supports the need for continuing training and awareness for front line police services and medical emergency personnel on the medical condition known as "excited delirium" .

2. ***That the Ontario Police College:***
 - (i) ***Enhance and continue its efforts to ensure that new recruits are taught:***
 - (a) ***About the signs and symptoms of excited delirium;***
 - (b) ***That excited delirium constitutes a medical emergency; and***
 - (c) ***The risks associated with the physical restraint of persons experiencing an episode of excited delirium.***
 - (ii) ***It is recommended that the Ontario Police College enhance and continue to include in the training program the practice of requiring all healthy trainees to experience firsthand the process of being physically restrained in the prone position.***

RATIONALE:

The evidence presented at this inquiry overwhelmingly supports the need for continuing training and awareness for front line police services on the medical condition known as "excited delirium".

3. ***That the Ontario Police College, the Chief of Police of the Toronto Police Service and the Toronto Police Services Board:***

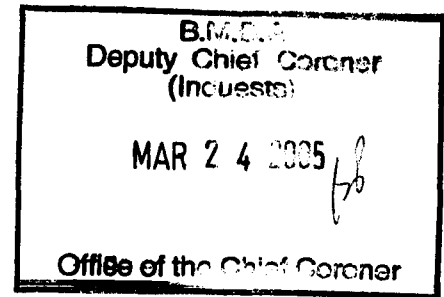
Consider the inclusion of the facts surrounding Nicholas Blentzas' death in the scenario role-playing exercises or case studies they use to train officers on excited delirium. Any such reference to the facts in this case shall ensure complete anonymity on behalf of Nicholas Blentzas.

RATIONALE:

The events leading up to the unfortunate death of Nicholas Blentzas should serve as a teaching scenario for future training case studies .

VERDICT EXPLANATION

Name of the Deceased: Nicholas Blentzas
Dates of Inquest: March 2nd – 15th, 2005
Location of Inquest: Coroners Courts,
15 Grosvenor Street,
Toronto, Ontario



I intend to give a brief synopsis of the issues presented at this inquest and explain the reasons for the jury's recommendations. I would like to stress that much of this will be my interpretation of the evidence and also my interpretation of the jury's reasons. The sole purpose for this is to assist the reader to more fully understand the verdict and the recommendations of the jury. It is not intended to be considered as actual evidence presented at the inquest, and is in no way intended to replace the jury's verdict.

Participants:

Counsel to the Coroner: Mr. David Carruthers

Investigating Officer: Detective Constable Barb Spoelstra
Ontario Provincial Police, Greater Toronto Region

Coroner's Constable: Constable W.G. Annand
Ontario Provincial Police, Niagara Detachment

Court Reporter: Ms. Charmaine White
Network Court Reporting
One First Canadian Place
100 King St. West, Suite 3210
Toronto, Ontario M5XZ 1E3
Telephone: (416) 359-0305

Parties with standing:

1. Chief of Toronto Police Service, represented by Ms. Michelle Farrell and Mr. Jerome Wiley.
2. Toronto Police Service Board, represented by Ms. Kalli Chapman.
3. Toronto Police Service Officers, represented by Mr. Gary Clewley.
4. Dr. John Deliakis, represented by Ms. Christine Lonsdale.
5. Blentzas family, represented by Ms. Jean Buie.

Summary of the Circumstances of the Death:

Nicholas Blentzas was 24 years of age at his death. On June 22, 2002 Toronto Police Service officers were dispatched to an apartment building for a report of a man striking a door with a fire extinguisher, and arrived to find Mr. Blentzas throwing himself against

his apartment door. Mr. Blentzas told the officers that he was being treated for a psychiatric illness, and agreed to accompany them to hospital for an assessment. He went voluntarily with the officers in the elevator, but ran away when its doors opened in the lobby. The officers gave chase and caught up with him across the street, where they attempted to restrain him physically and with oleoresin capsicum (pepper spray) in order to arrest him under the Mental Health Act. An ambulance was called, and paramedics arrived to find him lying on the ground with no vital signs. Resuscitative efforts were unsuccessful and he was pronounced dead at Toronto East General Hospital. The investigating coroner ordered that a postmortem examination be performed at the Coroners Building in Toronto.

An inquest was mandatory under Section 10 (5) of the Coroners Act because the decedent died while being detained by police officers. The jury heard five days of evidence followed by summations, and then deliberated for one day before returning with its verdict. In total, twenty-one witnesses testified and twenty-two exhibits were introduced as evidence. There was testimony regarding Mr. Blentzas' psychiatric history, the events on the day of his death and the findings on postmortem examination. There was also evidence concerning excited delirium, the SIU investigation into the incident, the training of Toronto Police Service officers, methods used by police officers to restrain individuals and requirements for detaining individuals under the Mental Health Act.

Verdict of Coroner's Jury:

The jury determined the following:

1. Name of Deceased: Nicholas Blentzas
2. Date and Time of Death: June 23, 2002 at 2:20 am
3. Place of Death: Toronto East General Hospital
4. Cause of Death: Excited Delirium/Restraint Asphyxia associated with an underlying psychiatric illness
5. By what means: Accidental

Jury Recommendations:

The jury made the following recommendations:

Recommendation #1.

“That the Chief of Police of the Toronto Police Service and Toronto Police Services Board:

- (i) Enhance and continue to ensure that new recruits are taught:
 - (a) The signs and symptoms of excited delirium;
 - (b) That excited delirium constitutes a medical emergency; and
 - (c) The risks associated with the physical restraint of persons experiencing an episode of excited delirium.

- (ii) Enhance and continue to ensure that all police officers and court officers receive a yearly refresher, during their training, on oleoresin capsicum (pepper spray), emphasizing:
 - (a) The signs and symptoms of excited delirium;
 - (b) That excited delirium constitutes a medical emergency; and
 - (c) The risks associated with the physical restraint of persons experiencing an episode of excited delirium.”

Jury’s Rationale: The evidence presented at this inquiry overwhelmingly supports the need for continuing training and awareness for front line police services and medical emergency personnel on the medical condition known as “excited delirium.”

Coroner’s Comments: The jury heard evidence that individuals with excited delirium exhibit hallucinations and violent behavior, and may need to be restrained by police officers to permit transportation to hospital for psychiatric care. However, restraint in the prone position may increase their risk of sudden death. This recommendation is intended to promote education of police officers about excited delirium to assist them to recognize it, avoid prolonged restraint in the prone position if possible and arrange for emergency medical treatment.

Recommendation #2.

“That the Ontario Police College:

- (i) Enhance and continue its efforts to ensure that new recruits are taught:
 - (a) About the signs and symptoms of excited delirium;
 - (b) That excited delirium constitutes a medical emergency; and
 - (c) The risks associated with the physical restraint of persons experiencing an episode of excited delirium.

- (ii) It is recommended that the Ontario Police College enhance and continue to include in the training program the practice of requiring all healthy trainees to experience firsthand the process of being physically restrained in the prone position.”

Jury’s Rationale: The evidence presented at this inquiry overwhelmingly supports the need for continuing training and awareness for front line police services on the medical condition known as “excited delirium.”

Coroner’s Comments: The jury heard evidence that that new police recruits are taught about excited delirium during their mandatory training at the Ontario Police College. This training includes the signs and symptoms of excited delirium, the fact that it is a medical emergency and the increased risk of death associated with restraint in the prone position. Healthy trainees are restrained in the prone position themselves to demonstrate

the dangers of this position. This recommendation is intended to encourage the continuation and enhancement of this training at the Ontario Police College.

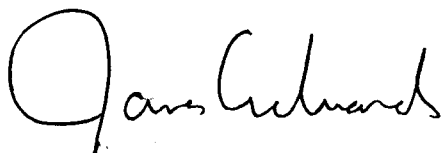
Recommendation #3.

“That the Ontario Police College, the Chief of Police of the Toronto Police Service and the Toronto Police Services Board consider the inclusion of the facts surrounding Nicholas Blentzas’ death in the scenario role-playing exercises or case studies they use to train officers on excited delirium. Any such reference to the facts in this case shall ensure complete anonymity on behalf of Nicholas Blentzas.”

Jury’s Rationale: The events leading up to the unfortunate death of Nicholas Blentzas should serve as a teaching scenario for future training case studies.

Coroner’s Comments: There was evidence that most police officers have not encountered an individual with excited delirium because it is not a particularly common condition. The jury felt that using the specific circumstances of Nicholas Blentzas’ death as a teaching tool would be an effective method of teaching officers about excited delirium.

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury verdict. It is worth repeating that it is not the verdict. Likewise, many of the comments regarding the evidence are my personal recollection of the same and are not put forward as actual evidence. If any party feels that I made a gross error in my recollection of the evidence or a conclusion of the jury, it would be greatly appreciated if it could be brought to my attention and I will correct the error.



James Edwards, M.D.
Presiding Coroner
March 21, 2005