“Time is on your side.” A proposal for upgrading “First Responder Training For Those With Seizure Disorders.”
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We are:

A project team comprised of police officers, retired police officers, administrative and health care professionals, and epilepsy advocates that have a specific interest in training regarding seizure disorders.

Our project team realized the similarities between seizure disorders and other “non-responsive” conditions, like autism and diabetic shock. We also acknowledge that a technique can be used by first responders to minimize the danger to the subject and others present, including the first responder.

We also acknowledge that this is a co-ordinated re-examination of existent training. Training that can save lives.

Our Values:

1. To ensure that all persons living with seizure disorders are treated fairly and can feel comfortable if they must deal with first responders.
2. Ensure there is help for those with seizure disorders, utilizing avenues that are difficult to access as an individual.

Our Mission:

To develop and implement a Canadian training program to better equip first responders to recognize and deal with actions displayed by those who may be presenting seizure disorder characteristics.

Our Vision:

To incorporate the optimal aspects of existing Canadian seizure disorder training combined with proven effective training that is similar.
# Table of Contents

Think Epilepsy-Who we are........................................................................................................... 3

Training and the Use of Force Model.............................................................................................. 5

Time is on our side.......................................................................................................................... 6

Examining a seizure-time is on our side......................................................................................... 7

Generalized Seizures...................................................................................................................... 8

Focal seizures with a loss of awareness......................................................................................... 10

Post-ictal Behaviour...................................................................................................................... 11

An officer’s power to act ................................................................................................................. 13

Active-Listening De-Escalating Dynamic Containment Strategy.................................................. 16

   Introduction................................................................................................................................. 16

   Non-responsive Subject Incident Confusion............................................................................ 16

   Primary Officer’s Role.............................................................................................................. 17

   Supporting Officers’ Role........................................................................................................ 17

   Indoor Response....................................................................................................................... 18

   Outdoor Response.................................................................................................................. 19

   Communication Strategies..................................................................................................... 20

   Why upgrade the CPKN training............................................................................................ 23
Training and the Use of Force Model:

A Use of Force Model is used in all police services in North America. It dictates the level of force used by any officer in any critical situation. The officer uses the most reasonable option relative to that situation.

Ontario has utilized a Use of Force Model since 2004. It ranges from officer presence to utilizing lethal force via his/her sidearm. Their personal abilities and physical stature are factors that impact their response.

Today, there are more effective methods being sought to de-escalate critical incidents. Even the use of the terminology is being change. “De-escalation” is a more favorable term for obvious reasons. The officer may face a critical incident with a different underlying philosophy. “Force” is not the prevailing thought when one enters a critical incident. De-escalation becomes the prevailing motivation.

Homogenous training techniques for police officers/first responders across Canada is essential to avoid some lethal outcomes. Officers remembering the theme that “time is on their side” is essential in possibly avoiding lethal outcomes in these critical situations.

Presently, there is training for those with seizure disorders available on The Canadian Police Knowledge Network (cpkn.ca); however, there is no motivation for officers to enroll in the training unless they are mandated to complete the training or they have their own personal interest in the subject. Upon completion of the design of the training, we were aware of this obstacle.

It was surmised that Volume 1 of the training would introduce identification and a response to critical incidents involving those with seizure disorders. The subsequent Volume 2 would introduce street policing tactics and a new de-escalation protocol that is more effective and less lethal (Active Listening De-escalating Dynamic Containment Strategy).

Most importantly, one must disregard a linear relationship with the model when dealing with one that has a seizure disorder, the incident may escalate or de-escalate so rapidly that assessing the situation with a linear mindset may convolute your response. An appropriate response for the specific act at the time may be more appropriate than a response to an act that prompted your presence there in the first place. Adopting a Use of Force Model similar to Las Vegas, Nevada is incredibly appropriate when utilizing the Active Listening De-escalating Dynamic containment Strategy. This model clearly intonates that an officer can influence the outcome based on the tactic he chooses. For example, the simple tactic of attempting to effect control of subject with a seizure disorder would play a significant role in the outcome. Most persons will react negatively
to one that attempts to take control of their person. Especially, if that person is not known to them and/or in an intimidating role.

To date, the most innovative response to subjects that are actively resistant is the taser. However, from the perspective of subjects that are clearly displaying post-ictal behaviours, this can be a lethal response. Identification that the subject has a seizure disorder is a significant aspect of the front-line investigative process. Recently updated databases and information from witnesses (even the complainant) is significant.

Elementary investigative techniques and the utilization of the *Active Listening De-escalating Dynamic Containment Strategy (DDCS)* is an appropriate technique in all critical situations where tactical and safety considerations permit. This strategy should remain dynamic and altered as per coroner jury recommendations.

In many critical incidents, an officer can be disciplined as a result of his actions. In many occurrences, the officer’s response is a result of ignorance. His sophistication in the subject may prevent a re-occurrence. At the very least, it would be clear for an independent entity to determine their complicity in an immoral act thereafter. The disposition of this act could consist entirely or partially in enrolling in training, a cost-effective solution.

**Time is on our side**

Today, for a variety of reasons, officers with less experience consider time a significant component in a critical situation. A concise solution is considered the most effective response. For example, there could be high priority occurrences occurring simultaneously or an entity within their immediate environment requesting a prompt conclusion. A common understanding amongst experienced officers is that expediting a conclusion can have an inverse relationship. The response may escalate the situation.

As stated earlier, “time is on our side”. De-escalation strategies are all primarily based on this theme. If there is no imminent danger to any persons, including the officer, then there is no need to use force. All alternative strategies should be examined. Utilizing time and space is significant. If there is no danger to any persons, why risk danger by using force? Explore alternative strategies, especially with persons displaying post-ictal behaviour.

Principals utilized with persons exhibiting post-ictal behaviour are similar to those used with mental illnesses and/or emotionally disturbed. The ultimate question is when do you act? The answer is until they present a danger to someone, including themselves.

Often, an officer’s presence alone can be a powerful de-escalating option. If utilized properly with an accurate perception of his threat, the officer can resolve the critical incident without even considering a lethal option until the subject displays assaultive
behaviour. Distance is an integral factor that must accompany their presence. It diminishes the threat to both the subject and the officer.

**Examining a seizure - time is on our side**

There are 42 different types of seizures. Many associate involuntary motor function as the *only* type of seizure that exists. There are several other types of behaviours that associate a seizure that make it more difficult to determine that it is a seizure.

*In general, the whole episode lasts from 5-30 minutes.*

In urban areas, all parties within first responders (fire, ambulance, and police) can arrive simultaneously or within a brief time of each other. In rural areas, this may not be the case. In general, seizure may be identified as the following:

There are several different types of seizures. Most seizures can be categorized as either focal or generalized.

**Generalized Seizures**¹

Generalized seizures occur when there is widespread seizure activity in the left and right hemispheres of the brain. Generalized seizures are usually brief and easy to identify as a seizure.

**Tonic-Clonic Seizures**

During a generalized tonic-clonic (formerly grand mal) seizure, electric discharges instantaneously involve the entire brain. The person loses consciousness right from the beginning of the seizure.

A tonic-clonic seizure usually lasts one to three minutes, but may last up to five minutes. If seizures last more than five minutes, or occur one after another without recover between seizures, the individual may be experiencing. This continuous seizure state is a life-threatening medical emergency and requires immediate medical help.

The person will usually emit a short, loud cry as the muscles in the chest contract and the air rushes between the vocal cords, making a sound. This cry does not indicate pain. The muscles will stiffen (tonic phase), causing him/her to fall to the floor. Increased pressure on the bladder and bowel may cause wetting (urinary incontinence) or soiling (fecal incontinence). The child may bite the tongue, which may cause bleeding.

The extremities will then jerk and twitch rhythmically (clonic phase). Saliva that has not been swallowed during the seizure may froth at the mouth. Breathing may be irregular.

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as the respiratory muscles may be affected. The person will regain consciousness slowly.

First Aid

- Keep calm.
- Protect the child from further injury.
- **Do not restrain the person.**
- Do not insert anything in the mouth.
- Roll the child on his/her side after the seizure subsides.
- If a seizure lasts longer than five minutes or repeats without full recovery, seek medical assistance immediately.
- Talk gently to the person after the seizure.

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**Focal (or partial) seizures**

Focal (or partial) seizures occur when seizure activity is limited to a part of one brain hemisphere. In a critical situation, *this may be the most important type of seizure for an officer to recognize.* It is the type that may mimic someone under the influence of a controlled substance or a mental health condition. There is a site, or a focus, in the brain where the seizure begins. There are two types of focal seizures:

- **Focal seizures with retained awareness** This type of focal seizure was previously known as a simple partial seizure.
- **Focal seizures with a loss awareness** This type of focal seizure may also be called a focal dyscognitive seizure (previously known as complex partial seizures)

**Focal seizures with retained awareness**

This type of seizure originates within one brain hemisphere and does not impair awareness or consciousness. During the seizure, the person will be able to communicate and will remember the episode afterwards.

Some people have full awareness at the very beginning and then their seizure evolves, or spreads, and can result in a **Focal Dyscognitive Seizure**, or a generalized **Tonic-Clonic Seizure**.

Focal seizures take different forms in different people. The person’s sense may be distorted causing him/her to see, hear or smell things that are not real. He/she may

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also experience unusual feelings. All these symptoms are further classified into four categories:

First Aid

- Supervise the person and gently guide him/her away from potential danger
- **Do not restrain the person since he/she may instinctively lash out or become highly agitated.**
- Comfort the person during and following the seizure.
- Remain with the person until full awareness returns.

Focal seizures take different forms in different people. The person’s sense may be distorted causing him/her to see, hear or smell things that are not real. S/he may also experience unusual feelings. All these symptoms are further classified into four categories:

i. Autonomic Seizures

These seizures are accompanied by autonomic symptoms or signs, such as abdominal discomfort or nausea which may rise into the throat (epigastric rising), stomach pain, the rumbling sounds of gas moving in the intestines (borborygmi), belching, flatulence and vomiting. This has sometimes been referred to as abdominal epilepsy. Other symptoms may include pallor, flushing, sweating, hair standing on end (piloerection), dilation of the pupils, alterations in heart rate and respiration, and urination. A few people may experience sexual arousal, penile erection, and orgasm.

ii. Emotional and Other

Focal seizures which arise in or near the temporal lobes often take the form of an odd experience. One may see or hear things that are not there. One feels emotions, often fear, but sometimes sadness, anger, or joy. There may be a bad smell or a bad taste, a funny feeling in the pit of the stomach or a choking sensation. These seizures are sometimes called focal seizures of temporal lobe origin or temporal lobe auras.
iii. Motor

Other focal seizures include (clonic, jerking) convulsive movements. Jerking typically begins in one area of the body — the face, arm, leg, or trunk — and may spread to other parts of the body. These seizures are sometimes called Jacksonian motor seizures; their spread is called a Jacksonian march. It cannot be stopped so let the seizure run its course and end on its own.

iv. Sensory Seizures

Some focal seizures consist of a sensory experience. The person may see lights, hear a buzzing sound, or feel tingling or numbness in a part of the body. These seizures are sometimes called sensory seizures.

First Aid

- Supervise the person and gently guide him/her away from potential danger
- **Do not restrain the person since s/he may instinctively lash out or become highly agitated.**
- Comfort the person during and following the seizure.
- Remain with the person until full awareness returns

Focal seizures with a loss awareness

This type of focal seizure may also be called a focal dyscognitive seizure (previously known as complex partial seizures)

   **Focal Dyscognitive Seizure:** *(formerly complex partial seizures or psychomotor seizures)*

A focal dyscognitive seizure does not involve convulsions, but it does impair awareness or consciousness. During the seizure, the person may be unable to respond to questions.

Focal dyscognitive seizures can begin in different regions or brain networks. For a given individual, seizures will be similar each time because the same brain region(s) are often involved.

A common brain region where focal seizures can originate is the temporal lobe. During a focal dyscognitive seizure originating from this brain region, the person...
stops and may have a blank look or empty stare. S/he will appear unaware of the environment and may seem dazed. The individual may manifest any of the following “inappropriate” automatic behaviours:

- chewing movements
- uncoordinated activity
- meaningless bits of behaviour that appear random and clumsy including picking at their clothes or trying to remove them, walking about aimlessly, picking up things, and mumbling.

A focal dyscognitive seizure usually lasts about two to four minutes. After the seizure, there is usually a period of confusion.

**Post-Ictal Behaviour**

The postictal state is the abnormal condition occurring between the end of an epileptic seizure and return to baseline condition. Applying this definition operationally can be difficult, especially for complex partial seizures, where cognitive and sensory motor impairments merge imperceptibly into the postictal state. ([https://www.ncbi.nlm.nih.gov/pubmed/20692877](https://www.ncbi.nlm.nih.gov/pubmed/20692877))

It is this behaviour that accompanies a seizure that first responders have seen during some of the critical incidents within this report.

**The post-ictal phase can generally last 15-20 minutes.** The seizure itself can last a few seconds to a few minutes.

*It is rare, however, there is times where psychosis accompanies the post-ictal phase. This behaviour is characterized by: auditory and visual hallucinations, delusions, paranoia, affective change, and aggression.*

Many patients are unaware of even having had a seizure. In general, an officer wouldn’t be attending a critical incident of this nature alone. He may have fire and ambulance already present or en route. As a result, there are others to confer with during the incident. Others with more sophisticated knowledge to help the officer assess, plan, and act.

Once again, an officer must realize that time is on their side. There are paramedics that attend a call of this nature simultaneously. If there is no imminent danger to any persons and the environment is controlled, there may be no need to act.

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An officer’s power to act:

In general, an officer is attending the critical incident because someone has requested that the officer attend. The complainant will have vital information for that officer. The more intimate the complainant is with the subject, the more valuable the information. Information that the subject has a seizure disorder will help an officer organize their options. Their personal abilities will augment their ability to act. Their perceived confidence is an integral factor when utilizing the DDCS.

In most cases, when assessing their options, an officer will determine their powers of arrest before they act. They must articulate why they chose their response. Their response will be scrutinized by their supervisor, their peers, the legal community, and/or social media community.

In general, the following:

1. **Ontario Mental Health Act (MHA)**

A person with a seizure disorder is not necessarily mental unstable. Focal seizures can mimic signs of a mental illness. Further, a mental illness may be a byproduct of the seizure disorder itself. As a result, an officer’s response may utilize the Mental Health Act.

Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,
and in addition, the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,
and that it would be dangerous to proceed under section 16, the police officer may take the person in custody to an appropriate place for examination by a physician.

2000, c. 9, s. 5.
An officer must articulate their actions after the critical situation. If they have had to utilize any action, they must document that action for scrutiny. When dealing with a subject that has a seizure disorder, the behaviour that prompted a police response usually is interpreted as mental instability; therefore, the power of arrest most commonly used is the MHA.

The person they are dealing with is likely experiencing a focal seizure. The symptoms of this seizure are temporary. The behaviours associated with the seizure may include non-responsiveness. As a result, the officer interprets that the disorder is of a nature that will result in serious bodily harm to the subject and/or others. The officer may also interpret that the behaviours may result in physical impairment of the subject.

As stated, the officer has been trained to articulate their actions after a critical incident. Therefore, they must articulate their grounds to act or their reason to physically interact with the subject. If there is any behaviour to indicate mental instability, the officer must articulate why they believed the subject was no longer a threat. Otherwise, they may take the subject in custody to an appropriate place for examination by a physician. The officer must accompany the subject until an attending physician can examine the subject. This process can take as long as twelve hours.

Criminal Code of Canada

There are criminal code authorities to detain someone with a seizure disorder. It can be used as a generic authority until a further investigation is conducted. The authority is as follows:

1. Arrest without warrant (Criminal Code of Canada):

   Arrest without warrant by peace officer

495 (1) A peace officer may arrest without warrant

   (a) a person who has committed an indictable offence or who, on reasonable grounds, he believes has committed or is about to commit an indictable offence;

   (b) a person whom he finds committing a criminal offence; or

   (c) a person in respect of whom he has reasonable grounds to believe that a warrant of arrest or committal, in any form set out in Part XXVIII in relation thereto, is in force within the territorial jurisdiction in which the person is found.

Limitation

(2) A peace officer shall not arrest a person without warrant for

   (a) an indictable offence mentioned in section 553,
(b) an offence for which the person may be prosecuted by indictment or for which he is punishable on summary conviction, or

(c) an offence punishable on summary conviction,

in any case where

(d) he believes on reasonable grounds that the public interest, having regard to all the circumstances including the need to

  • (i) establish the identity of the person,
  • (ii) secure or preserve evidence of or relating to the offence, or
  • (iii) prevent the continuation or repetition of the offence or the commission of another offence,

may be satisfied without so arresting the person, and

(e) he has no reasonable grounds to believe that, if he does not so arrest the person, the person will fail to attend court in order to be dealt with according to law.

Consequences of arrest without warrant

(3) Notwithstanding subsection (2), a peace officer acting under subsection (1) is deemed to be acting lawfully and in the execution of his duty for the purposes of

(a) any proceedings under this or any other Act of Parliament; and

(b) any other proceedings, unless in any such proceedings it is alleged and established by the person making the allegation that the peace officer did not comply with the requirements of subsection (2).

R.S., 1985, c. C-46, s. 495; R.S., 1985, c. 27 (1st Supp.), s. 75.

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When an officer is dealing with someone who is experiencing a seizure disorder, they are usually attending because the subject is displaying behaviour that is disturbing the public peace and/or presenting imminent danger to themselves or others. One who has a seizure disorder will display behaviour categorized under the Mental Health Act. Often the behaviour isn’t criminal or the officer’s duty to act may preside under the Mental Health Act v.s. the Criminal Code of Canada.

If an officer has to act under this authority, he must determine that the subject presents no threat to themselves as a result of their mental condition. Often the behaviours determined to be a mental instability must be concluded to be a seizure by first responders. Without previous documentation (medical records, police documentation, complainant’s statement, etc.), a variety of interpretations can be made.
Ontario Trespass to Property Act (TPA)

A person with a seizure disorder may have an episode on property that he neither owns or rents, as a result an officer may use the Ontario Trespass to Property Act as his right to arrest and remove from the property. This power of arrest should only be considered to remove the subject from the property and establish a further investigation regarding his condition, preferably in conjunction with other first responders.

Trespass an offence

2. (1) Every person who is not acting under a right or authority conferred by law and who,

(a) without the express permission of the occupier, the proof of which rests on the defendant,

(i) enters on premises when entry is prohibited under this Act, or

(ii) engages in an activity on premises when the activity is prohibited under this Act; or

(b) does not leave the premises immediately after he or she is directed to do so by the occupier of the premises or a person authorized by the occupier,

is guilty of an offence and on conviction is liable to a fine of not more than $10,000. R.S.O. 1990, c. T.21, s. 2 (1); 2016, c. 8, Sched. 6, s. 1.

Sometimes, the TPA is the only authority an officer has to remove a subject from the premises and establish an investigation to establish the origin of the behavior.
Active Listening De-escalating Dynamic Containment Strategy  
**D.D.C.S.**

**Introduction**

The Active Listening De-escalating Containment Strategy depicts a strategy that is self-explained. It is not re-inventing the wheel. It is a common strategy utilized amongst seasoned officers that prefer to resolve a critical incident without a catastrophic conclusion. The DDCS is designed to provide a limited threat to the subject, while maximizing the safety of the responding officer in the exercise of their duty.

Two officers are usually best when they are ready to employ the DDCS. The officer should also rely upon data on their local database, CPIC, the complainant’s information, and any other witness information at the incident. Unless the subject has just moved in and was just recently diagnosed, it is likely that there is a record of previous behaviour.

DDCS takes the abovementioned into consideration and employs techniques that are not novel. Officers with more experience would regularly employ these tactics; however, they are not formally taught.

DDCS still understands that the officer’s safety is paramount. It places the subject and the officer in an environment that is incrementally less threatening as techniques and options like active listening and officer presence are employed.

**Non-Responsive Subject Incident Confusion**

It is well known amongst the law enforcement community that officers with less experience naturally run into a critical incident wanting to resolve the issue. DDCS teaches that time is on our side. Utilizing techniques active listening and employing distance to assist a tactical withdrawal are integral aspects of DDCS. They naturally de-escalate any incident involving those with a seizure disorder.

It is this behaviours that is usually confused with one consuming a controlled substance or under the influence of alcohol. Urban police services have support teams that are likely on scene with them re: ambulance (OAC and fire). These services usually have one drug recognition expert per shift. Ontario rural officers also have officers that are gradually being trained in drug recognition. The sophistication is within the police services to distinguish between drug consumption and MHA subjects. The concern is how expeditious the officers are in attending the scene upon the commencement of the critical incident.
Primary Officer’s Role

Primary officers can utilize their presence and active listening to facilitate the time for these officers to attend. These officers are also using policing techniques to distinguish the origin of the subject’s behaviour. The officer is assessing the following:

- Responsiveness
- Controlled substance use?
- Alcohol intoxication?
- Points of entry
- Threats (weapons, subject’s physical threat)

The officer is utilizing aspects of active listening like:

- Portraying complete attention via paraphrasing and acknowledging any communication
- Using body language and gestures to convey attention and a comfortable, safe environment
- Provide feedback
- Defer judgment
- Respond appropriately

Silence should not be understated as an active listening technique.

The officers on scene can also rely on their support teams (all first responder dispatchers and CPIC operators) for more data as he is conducting his active investigation. The officer is relaying all information procured from evidence at the scene.

Unless the safety of the first responders is at risk, too many officers at the scene may hamper any progress. The subject may feel threatened by too many persons in the room that are not in direct communication with them.

Supporting Officers’ Role

As stated earlier, too many officers may threaten the subject. Their proximity and unconscious body language may augment the negativity. The secondary staff is monitoring entrances and escape routes. They are also scanning the area for any weapons of opportunity.

If the primary officer is not effectively communicating with the non-responsive subject, a secondary officer may take the primary role. The secondary officer may have more investment in the community and may have some familiarity or a better rapport with the subject.
**Indoor Response**

The officer arrives on scene and immediately acknowledges all points of entry. There are usually one to two points of entry to a room. More than two entries to an uncontrolled environment creates too many factors for two officers to deploy DDCS; however, this is possible with more than two officers. Manpower may not allow for this deployment.

The primary officer remains at the primary point of entry. The officer deploys distance to maximize safety. Optimally, there is a large fixed object between the officer and the subject.

The secondary optimally is at a 90 degree angle with the subject and within a non-threatening distance.

The primary officer ensures that weapons and/or weapons of opportunity are out of reach of the subject. He/she may decide to place themselves between the weapon and the subject.

Secondary officers can assess controlled environments within the scene. Optimally, there are adjoining controlled environments.

If the subjects displaying seizure disorder behaviors’ are within controlled environments, the officer can utilize active listening techniques until the seizure subsides. He should remember that once the seizure is identified, time is on his/her side. They simply have to observe the behaviour, utilize active listening, and ensure that there is no imminent danger presented to the subject or others. There is no need for the officer to act or attempt to an arrest. It is clearly indicated that physical contact with one experiencing a seizure can quickly escalate the critical situation.

Throughout the occurrence, the officer continues his investigation. The secondary officer can also be assessing other safe area within the scene.

The officers’ primary goal at this point is containment. The subject should remain in a safe area where there is no imminent danger. Officer presence and possibly tactical communication are very important at this stage.

The officer must use his/her presence and funnel the subject into safe areas via gestures and his presence if the subject becomes mobile. The officer must always remain in control; however, he must also use tactical retreat as a technique during this process. He can be retreating while still communicating with the subject. Distance should be maintained while moving with the subject. The officer should simultaneously be assessing the subject’s own body language and/or gestures.
When the subject becomes mobile, the secondary officer’s role becomes more significant. At times, if it is known that an adjoining area is safe, the officer can allow the subject to pass them and utilize the secondary officer’s abilities to funnel the subject. The officers should be cognizant of the fact the subject is experiencing a seizure that is temporary. While employing these techniques, more time is exhausted regarding the subject’s seizure.

If the subject becomes mobile, the situation remains dynamic; however, if officers acknowledge that the philosophy behind DDCS is to ensure the subject is in a safe environment, the strategy can be maintained without prematurely being physical with the subject. The officers remember that their presence is a powerful use of force option. When utilized confidently, funneling the subject into safe environments can be achieved without escalating the situation. Escalation of an incident can result in severe injury or death.

Utilizing the DDCS does not preclude an officer’s responsibility to deploy the appropriate use of force option if the situation does escalate. Not any one occurrence is the same. There may be factors within the occurrence that an officer may not be able to appropriately assess to create a plan regarding the DDCS. *If the safety of an officer or a member of the public is compromised the officer must act.*

**Outdoor Response**

An outdoor approach utilizes the exact principles as indoors; however, the optimal area for an outdoor approach is an outdoor area with fixed barriers on three sides and one point of entry. The primary officer controls the one point of entry and can utilize distance and time as his tools until the seizure subsides.

The secondary officer, if available, can utilize the 90 degree approach from a safe area or monitor the outdoor point of entry where it no longer is controlled. An outdoor sidewalk adjoining the yard is a good example.

As stated, there is limited manpower for policing agencies in today’s era. If there are officers to control the outside sidewalk, then the safe environment is expanded and the officers can tactically retreat using distance and time because time is on their side. The officer’s will utilize their presence and active listening skills to maximize their chances of a successful conclusion.

Obviously, these conditions won’t always exist. The officer can attempt to utilize the fixed barriers in the area to assist with controlling the environment. Where this doesn’t exist, the officer(s) can utilize distance in an open area and control the space required to maintain control of the subject.
There is no need for the officer(s) to act until the subject and/or others are in imminent danger.

The officer(s) must realize that the general public or civilians within the environment cannot be placed in unnecessary danger. If the subject is displaying psychotic behaviour, the behaviour cannot be predicted. If civilians are in close proximity, they can be placed in immediate danger before an officer can act. Therefore, there can’t be civilians within the controlled environment.

The only exception is a relative or person intimate with the subject. In some case, it can be the complainant. They may be able to assist with communicating with the subject. In some cases, the civilian can be the communicator while the primary officer ensures the communicators safety (scans for weapons and ensures he can act before the subject places the civilian in danger). The officer has to make this judgment call at the scene by assessing how the subject responds. Body language, gestures and verbal responses are all tools at their disposal.

It is important that an officer realizes that a subject only needs medical attention if the following occurs:

1. the first time someone has had a seizure,
2. it’s the seizure lasts for more than five minutes, and/or
3. the person doesn’t regain full consciousness, or has a series of seizures without regaining consciousness

Sometimes, insistence to attend a medical facility when the condition doesn’t exist can escalate the critical situation once the seizure has subsided. Often, an officer believes that he has to fulfill his full duty and ensure there is medical attention before he concludes the call. The officer wants to ensure there is no liability. He/she knows that there will be scrutiny by colleagues and supervisors. If there is a negative outcome, they may be scrutinized by the Special Investigations Unit, their own Professional Standards Section (Internal Affairs), and/or social media community.

**Communication Strategies:**

As stated, the DDCS does not re-invent the wheel. Communication strategies evident in this report are strategies that are used amongst policemen worldwide. In fact, these same strategies are documented in the Constructive Public Interaction\(^5\) module

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\(^5\) Ministry of Community Safety and Correctional Services, Constructive Public Interaction, Lerner Resource,
embedded on cpkn.ca. The course is compulsory for all sworn officers in Ontario that interact with the public.

The following are some aspects of communication stressed in this report:

*Body Language*

Body language is the process of communicating nonverbally through conscious or unconscious gestures and movements. Poor body language displays disinterest—avoid eye rolling, nodding, shaking your head, looking away, foot tapping, hands in pockets, avoiding eye contact, etc. All components of communication work together in sending a message. When the communication components are in conflict, body language will dominate the message.

*Proxemics*

Proxemics is the study of personal space, which is defined as that area around your body you consider to be an extension of yourself (typically 1 ½ - 3 feet). We know that if you invade someone’s personal space, you may cause them to feel some discomfort or anxiety. Respecting personal space will enhance the communication process and prevent escalation of a situation. To ensure that we do not invade someone’s personal space, we use what is referred to as the “interview stance”:

- Respects personal space
- Less threatening
- Enhances officer safety (i.e., helps to maintain balance, pistol is kept furthest away, etc.)

Note that sometimes the personal space is dependent upon one’s environment. You may have limited space to correspond with the subject because of the nature of the environment that the incident has occurred (i.e. small bachelor apartment)

*Active Listening*

As a police officer, you rely on the public for information to effectively complete tasks. Active listening allows for greater accuracy of a message and shows respect toward the person providing the information.

Active listening refers to being intently engaged in communicating with someone to the point of fully understanding their point of view. It is an interactive process for improving the degree of understanding between two or more people.

Active listening allows for a greater level of communication. You can listen to someone speak to you, but an accomplished communicator engages to such a degree that shows they care about the sender and the message. This approach also displays a high level of respect for the individual or group.

Active listening techniques include:

- Open-ended questions
Open-ended questions elicit more information than closed questions. Using open-ended questions will encourage the individual to talk and hopefully you will obtain more information.

Example:

- “Why do you think it happened?”
- “Who do you think could have done this?”

The above-mentioned aspects of communication depict some, but not all aspects of communication. The Ministry of Safety and Correctional Services has listed the same and more communication strategies.

Also noted are de-escalation techniques. The listed de-escalation techniques can be useful; however, it should be noted that officers are dealing with someone that is non-responsive. Further, there may be key phrases that may escalate the critical incident that are not known to the officer. Non-responsive persons often have irregular brain activity. Many times, police authority or threat of restraint may be triggers to escalate the occurrence. Data regarding the subject and/or data from a complainant or one intimate with the subject may be helpful.

Front-line officers often have the greatest investment in their community. They are seen on a regular basis and interact with elements that directly impact the community they serve.

“Active listening and rapport-building techniques are paramount in building and maintaining strong community relationships.

How you engage with the public during the collection of identifying information will be critical to continuing the success of community policing and the level of trust it has created within your community. It may be necessary to forgo or walk away from a conversation to prevent the situation from escalating. Informed consent and respecting refusal are the keys to maintaining the community’s trust. How you engage individuals in an attempt to obtain information is more important to the community than if you succeed in obtaining information in each encounter.”

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6 Ministry of Community Safety and Correctional Services, Constructive Public Interaction, Lerner Resource
Why upgrade the CPKN training?

Policing techniques should never remain static. There is always new conditions and factors that require a protocol to be altered or improved. Legislation is an integral, mitigating factor when considering these changes.

The investigation into the direction provided by the Ministry of Community Safety and Correctional Services to Ontario’s police services for de-escalation of conflict situations states “the time for “due diligence” on the part of the Ministry on de-escalation training is report on what steps they take, if any. I strongly encourage them to review the human costs of their legacy of inaction, and to finally make this issue a priority.”

We do note that the CPKN training has been available while several critical incidents have transpired, yet the enrollment could be stronger. There is competition with mandatory training that impact enrolment. The problem is the perspective of calls of this nature. Canadian police officers must acknowledge that a segment of the subject’s they interact with could be serviced more effectively with sophistication regarding those with seizure disorders. Principles within the DDCS can also be utilized with emotionally disturbed persons and those that consume controlled substances. While the strategy may not be effective homogenously, it is an option that does not exist.