VERDICT EXPLANATION

Inquest into the Death of
Robyn GARLOW

Dr. Geoffrey Bond, Presiding Officer
April 1 – 4, 2025
Virtual Inquest

OPENING COMMENT

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

PARTICIPANTS

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SUMMARY OF THE CIRCUMSTANCES OF THE DEATH

On the evening of October 17, 2018, Hamilton Police Service (HPS) officers were dispatched to a call regarding a suicidal female. One of the responding officers filled out a "Contact with Person in Crisis" (PIC) form. The PIC form detailed that Ms. Garlow had arrived at the apartment of her boyfriend's parents, wrote a note, went out on the balcony, and was about to jump before she was stopped by her boyfriend's father. It was noted that Ms. Garlow had used "crystal" in the previous 12 hours. The form also indicated that Ms. Garlow appeared to be overly suspicious, paranoid, confused, and disoriented.

The officers apprehended Ms. Garlow under section 17 of the *Mental Health Act* and transported her to St. Joseph's Health Care where she was triaged that evening. A Form 1 was initiated by the attending physician, and Ms. Garlow was kept overnight.

The next morning, Ms. Garlow met with a psychiatry resident. The resident noted that Ms. Garlow's presentation appeared to be one of acute substance intoxication which led to disorganization and suicidal ideation but cleared after the metabolism of the substance taken. It was noted that she had no current thoughts of self-harm. The Form 1 was lifted and Ms. Garlow was referred to and completed an intake with an addiction service for women. She was discharged shortly after noon on October 18, 2018.

On October 19, 2018, Ms. Garlow attended her father's residence. Ms. Garlow left Mr. Garlow's home a couple of times that evening, and he observed her to have a swollen arm when she returned, which he assumed was from drug use.

At around 11:30 p.m., Ms. Garlow had an upsetting phone conversation with family members who had recently moved to British Columbia. Following this discussion, Ms. Garlow began to act erratically and paranoid. She started looking out the window. She then left Mr. Garlow's unit with a knife and stated she was going to kill a neighbour.

Shortly thereafter, on October 20, 2018, a 911 call was placed by a member of the public at 12:43 a.m., from 321 King Street East. The caller stated that there was a female standing on his roof staring in his neighbor's window screaming that her son was there. HPS officers were dispatched to the area and the female was not located. The unknown female was later identified to be Ms. Garlow.

Approximately 10 minutes later, at 12:57 a.m., a 911 call was placed from 320 King Street East regarding Ms. Garlow. The caller was a neighbour of Ms. Garlow's father. The neighbour was calling on behalf of Mr. Garlow, who could be heard in the background. The neighbour advised that Ms. Garlow was trying to kill herself, that she had a knife, had cut herself in the neck area, and had tried to attack Mr. Garlow with a hammer.

Two police officers were dispatched to the scene at 1:01 a.m., arriving at around 1:06 a.m. The dispatcher advised the officers that Ms. Garlow had wanted to come at her father with a hammer, had a knife to her neck, and had cut herself there. She further advised that there had been some screaming, which had stopped, and that Ms. Garlow would be alone in Unit 2.

After their arrival on scene, the two officers learned that Mr. Garlow sustained a cut to his arm from Ms. Garlow. A hammer was observed outside. The officers had a brief discussion with Mr. Garlow, who led them upstairs to his apartment unit. He informed the officers that Ms. Garlow had a knife and was alone in the unit. He then entered the unit first followed by the officers. After exchanging words with Ms. Garlow, who could be heard yelling, the officers advised Mr. Garlow to exit the unit.

At 1:08 a.m., a 10-3 (keep radio frequency quiet) was requested by one of the officers. When asked by the officers if she had anything in her hands, Ms. Garlow indicated that she did and did not care. As the officers approached a hallway, where they could hear Ms. Garlow's voice coming from, one officer drew her conducted energy weapon (also known as a taser) and the other officer drew his firearm.

Upon nearing a doorway at the end of the hallway, Ms. Garlow was observed to be standing on a bed with a knife in her hand by her side. Within seconds of seeing the officers, Ms. Garlow brought the knife up to her neck and began cutting herself. She was ordered to drop the knife.

The female officer deployed the conducted energy weapon. She initially thought it was effective, based on Ms. Garlow's reaction, and both officers stepped into the bedroom with the intention of disarming Ms. Garlow. The officers then realized that the conducted energy weapon had not been effective. Ms. Garlow raised the knife above her head and

advanced towards the officers. The female officer was in the process of reaching for her gun when the male officer discharged his gun four times striking Ms. Garlow twice.

The male officer reported shots fired and requested EMS over the radio at 1:08 a.m., around 45 seconds after the 10-3 was requested. Hamilton Paramedic Services were already on scene when the shots were fired. The Ambulance Call Report indicated that a call was received at 1:02 a.m. about a suicidal female who was aggressive. An EMS crew arrived at 1:06 a.m. and was advised to wait for police to clear the scene prior to entering the building. A resident then came out of the building, advised the EMS crew that police were calling for paramedics, and they attended to Ms. Garlow. They transported her to the Hamilton General Hospital Emergency Department where resuscitation efforts continued.

Ms. Garlow was pronounced deceased at 2:04 a.m. on October 20, 2018. She was 30 years of age.

A forensic pathologist performed an autopsy on October 21, 2018. Postmortem toxicology was positive for methamphetamine, amphetamine, and methadone. The detected blood concentrations of methamphetamine and amphetamine in Ms. Garlow's blood were associated with the recreational use of methamphetamine. The detected concentrations were found not to have medically contributed to Ms. Garlow's death.

The forensic pathologist's report noted that Ms. Garlow had multiple, mostly horizontal cuts of variable length and depths across her neck. The report noted that the location and pattern of sharp force injuries to Ms. Garlow's neck were typically associated with self-infliction, were medically minor, and did not significantly contribute to the death.

The forensic pathologist's report also noted two gunshot wounds to Ms. Garlow's upper torso and concluded that Ms. Garlow's cause of death was attributed to gunshot wounds to the torso.

THE INQUEST

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

The document outlining the scope of this inquest is attached as an Appendix.

The inquest was conducted in a virtual manner, with remote participation by parties with standing and remote testimony from all witnesses. In keeping with the open court principle, the inquest was streamed live.

The jury sat for three and a half days, heard evidence from five witnesses, reviewed 15 exhibits and deliberated for two and a half hours in reaching a verdict.

VERDICT

Name of Deceased:	Robyn Garlow
Date and Time of Death:	October 20, 2018
Place of Death:	Hamilton General Hospital Site 237 Barton Street East
Cause of Death:	Gunshot Wounds to Torso
By What Means:	Homicide

RECOMMENDATIONS

To the Hamilton Police Service

1. Provide new recruits with Crisis Intervention Training before they receive Use of Force Training so that the skills that are learned during Crisis Intervention Training can be applied during Use of Force Training.

   Comments:

   The jury heard evidence that police recruits graduate from the Ontario Police College before they return to the Hamilton Police Service and receive additional training in-house. Currently, Use of Force Training precedes the in-person Crisis Intervention Training (CIT) that new recruits receive at the Hamilton Police Service. The jury suggests that the in-person CIT precedes the Use of Force training, so that the tools learned can be utilized and practiced in the Use of Force training, to reinforce the principle that de-escalation, if possible, should be the first approach in responding to a person in crisis call.

2. Extend the availability of Mobile Crisis Rapid Response Team (MCRRT) units to 24 hours a day and increase the number of MCRRT units to respond to calls regarding persons in crisis.

Comments:

The jury reviewed evidence and learned that the Mobile Crisis Rapid Response Team (MCRRT) was launched as a pilot project from November 2013 to April 2015. The initiative paired five mental health workers with police officers in a first-response capacity. Early results demonstrated positive outcomes, including reduced apprehension rates for individuals in crisis and shorter wait times for both police officers and clients in emergency departments. Due to its success, MCRRT became a full-time program in 2015.

The jury heard evidence that in October of 2018, there was no MCRRT coverage available after 1:00 a.m., which is when Ms. Garlow was in crisis. As at the time of this inquest, the MCCRT has eight full-time mental health clinicians and eight full-time crisis-intervention trained uniform police officers providing citywide coverage from 8:00 a.m. to 4:00 a.m. daily. The jury heard evidence that crisis calls also occur between the hours of 4:00 a.m. and 8:00 a.m. and recommends that 24 hour-coverage be available. The jury also heard evidence that there are times when the MCRRT is responding to another person in crisis call and cannot be deployed immediately and recommends an increase to the number of MCRRT units.

3. Consider implementing a dedicated Mobile Crisis Rapid Response Team (MCRRT) unit(s) for Central Hamilton, following needs-based analysis.

Comments:

The jury heard evidence that there is a relatively high incidence of mental health and/or substance use disorder calls in Central Hamilton. Given the higher incidence of these types of calls in that area, the jury suggests a needs-based analysis to determine if a dedicated MCRRT unit should be made available in Central Hamilton.

4. Explore the feasibility for all Communicators to have access to and be trained on utilizing local Records Management System (RMS) in order to provide responding officers with background information, specifically for high priority incidents, including but not limited to queries on involved people and addresses.

Comments:

Presently, communication staff do not have access to the local records management system (also known as NICHE), which is a record of previous occurrence reports. The jury heard evidence that when officers are responding to an urgent call, they often do not have time to look up an individual on NICHE in their vehicles. Having information about an individual's mental health, whether they have a history of substance misuse, and what their previous interactions with police were might prompt attending officers to request the MCRRT or possibly increased back up before engaging with the individual. It would also give officers more time to think about a plan of action before their arrival on-scene.

5. Add the following to the Suicide or Attempt Policy for Communicators under the responsibilities of Dispatchers:

    1. Query Location of Interest and provide results to the responding officers.

    2. Query CPIC and provide the results to the responding officers.

    Comments:

    The jury reviewed policy regarding what call takers, dispatchers and supervisors are to do when a suicide or attempt suicide call is received. The jury heard evidence that while dispatchers query location of interest and CPIC and provide results to the responding officers, it was not explicitly outlined in the policy.

6. Conduct annual refresher training on the Suicide or Attempt Policy for Communicators, emphasising the role and responsibilities of the Call Taker and Dispatcher.

    Comments:

    The Suicide or Attempt Policy that the jury reviewed included questions that a call taker is supposed to ask when a suicide or attempt suicide call is received. The jury also listened to the 911 call that was made regarding Ms. Garlow and certain questions were not asked by the call taker including whether drugs or alcohol was involved or if there was any history of suicide attempts or violence. The jury recommends annual refresher training in this regard.

7. Conduct an annual refresher on Crisis Intervention Training (CIT) for front-line officers.

    Comments:

    The jury heard evidence that the CIT that is delivered to Hamilton Police Service officers is forty hours in length and allows officers to have a better understanding of how to approach and respond to persons in crisis. The jury heard evidence that officers receive annual block training and are required to take annual recertification training when it comes to use of force and conducted energy weapon training. Given the importance of the information that is learned during CIT, the jury recommends annual refresher training in this area, as well.

8. Implement a voluntary operational debrief process for involved Hamilton Police Service members, including Communications staff, after the conclusion of a Special Investigations Unit investigation. Update all staff on lessons learned.

Comments:

In the present case, a debrief by the police service was not held after the completion of the SIU investigation into the shooting. Such a debrief might be useful to determine what, if anything, could have been done differently to have improved the outcome that occurred. The jury heard evidence that speaking about the events can be very stressful and traumatic for the persons involved. As such, the debrief should be voluntary.

9. Consider using the facts from the Inquest into the Death of Robyn Garlow to develop a training- based scenario for officers to complete during their annual recertification training.

Comments:

The jury heard evidence that the Hamilton Police Service develops scenarios that have occurred in real life to provide training to officers. The fact situation of the death of Robyn Garlow is representative of many of the factors that police officers might encounter when responding to a person in crisis call.

10. Explore the necessity for training that addresses trauma-informed approaches specific to Indigenous populations.

Comments:

The jury heard evidence that at the Ontario Police College, new recruits are taught a module that focuses on race, and that one of the teaching points is to understand that an officer's uniform carries a deeper meaning for many Indigenous people. The jury heard that officers being mindful of history and the impact it could have on an individual is an important part of rapport building. The jury suggests exploration for the necessity for training that is specific to Indigenous people and their experiences.

To All Police Services in Ontario

11. Consider providing Crisis Intervention Training as part of the post-OPC curriculum for all officers.

Comments:

The jury heard evidence that recent graduates of the Ontario Police College had received training in crisis intervention. However, not all senior police officers in the province have received this particular crisis intervention training. The jury suggests that all police officers should have training in this area.

12. Consider providing Crisis Intervention Training before they receive Use of Force Training so that the skills that are learned during Crisis Intervention Training can

be applied during Use of Force Training.

Comments:

See commentary in recommendation #1.

13. Consider providing an annual refresher on Crisis Intervention Training (CIT) for front-line officers.

Comments:

The jury heard evidence that calls regarding mental health and persons in crisis have increased. See commentary in recommendation #7.

To the Ontario Police College and the Ministry of the Solicitor General

14. Consider changing the online component of the Ontario Police College's Mental Health and Crisis Response Education and Applied Training to in-person.

Comments:

Although it is recognized that individuals may learn differently with any particular teaching method, evidence was given by an OPC trainer that the preference would be for the Mental Health and Crisis Response Education and Applied Training to be delivered in an in-person setting where interactions between the instructor and students could occur.

15. Consider including conductive energy weapon training as part of the mandatory curriculum for police recruits at the Ontario Police College.

Comments:

Use of conductive energy weapons (CEW) is currently not taught at the OPC. It is well recognized that conductive energy weapons are a use of force option that police officers can consider using in situations where an individual is non-compliant.

The jury heard evidence that there are several models of CEWs now in use in different municipal police services in Ontario. While it may not be feasible for the OPC to provide training on each type of CEW, the jury suggests that the general principles and tactics for the use of CEWs would be beneficial for new recruits to learn during their time at the OPC. Individual police services could then train officers on the CEW in use with their service.

CLOSING COMMENT

In closing, I would like to again express my condolences to the family of Robyn Garlow for their profound loss.

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

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

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

April 25, 2025

Dr. Geoffrey Bond
Presiding Officer

Date

APPENDIX

STATEMENT OF SCOPE

Inquest into the Death of Robyn GARLOW

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

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

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

1. Police training and practices concerning interactions with persons in crisis.

2. Police resources available to respond to persons in crisis who are Indigenous.

3. Police training and practices concerning interactions with, and potential apprehension of persons with an edged weapon.

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

1. Emergency or first-aid response provided to Ms. Garlow after the shooting.

2. The SIU investigation into the shooting.

3. An in-depth examination of previous healthcare and police interactions before Ms. Garlow's death, except to the extent that it provides context for the events that occurred in the hours preceding her death.