Ministry of Public Safety and Solicitor General

VERDICT AT INQUEST

File No.: 2009:0178:0030

An Inquest was held at the Supreme Court, in the municipality of Duncan

in the Province of British Columbia, on the following dates January 31 – February 3, 2011

before Mr. Rodrick H. MacKenzie, Presiding Coroner,

into the death of WELTON, Derek Wayne (Last Name, First Name Middle Name) 39 (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: March 1, 2009 at 19:40

Place of Death: Cowichan District Hospital (Location) North Cowichan, British Columbia (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Gunshot wound to the abdomen

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b)

DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) Other Significant Conditions Contributing to Death:

Classification of Death: ☐ Accidental ☒ Homicide ☐ Natural ☐ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 3rd day of February AD, 2011.

Rodrick H. MacKenzie
Presiding Coroner's Printed Name

Presiding Coroner's Signature

WELTON	Derek Wayne
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Mr. Rodrick H. MacKenzie

Coroner Counsel: N/A

Court Reporting/Recording Agency: Verbatim Words West Ltd.

Participants/Counsel: Carroll Welton/Michael G. Coleman
Attorney General of Canada/David Kwan

The Sheriff took charge of the jury and recorded the exhibits. Twenty (20) witnesses were duly sworn and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. The following summary of the evidence as presented at the inquest is to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

Mr. Welton lived a difficult life and suffered a violent death. He had to deal with the dual scourges of mental illness and drug addiction. He tragically lost his mother in his teen years which seems to have set him on a downward path. His pleasure in life was in his motorcycle and his dog. Mr. Welton had been employed by British Columbia Hydro, but at the time of his death he was on long term disability and living in a fifth wheel trailer.

His drug use aggravated his mental health issues. This led to a series of confrontations with the police. In November of 2006, he was charged with uttering threats, assault with a weapon, and two counts of assault of a police officer. He was found not guilty by reason of mental disorder. He was classed as unmanageable in the community and detained at the Forensic Psychiatric Hospital on Colony Farm Road Port Coquitlam, British Columbia.

In March 2008 he was released on conditions. By May 2008 he was again detained at the Forensic Hospital following yet another confrontation with police. December 2008 he appeared before the British Columbia Review Board. The treatment team recommended his continued detention. His counsel sought his absolute discharge. The Board concluded:

> [20] The Review Board considered the matter carefully, including the accused's tendency to be confrontive and threatening when intoxicated. Despite his historic record, it was difficult for us to conclude that the accused is more of a serious threat to others than he might be to himself given his stance in relation to law enforcement authorities. We also considered that the accused has no current or ongoing psychotic symptoms which, from a clinical prospective, warrant his further detention. Indeed he has been psychosis free for more than the period of his last order. In terms of the treatment team's wish to first see the accused discharged to a 24-hour supervised setting and notwithstanding his history, we did not view that this accused poses a sufficiently grave risk to others such as warrants his constant supervision. On

that note, given the rapid onset nature of his symptoms in the context of intoxication he is really no more amenable to a community supervisory response. In other words, even the level of supervision provided on a conditional discharge might be inadequate to prevent the accused from decompensation should he take the opportunity to use substances. We also take into account that the accused remains well known to authorities and services, as well as informal supports in his community. In terms of discharge subject to conditions the Victoria clinic makes it quite clear that they are less than enthusiastic about supervising this man in the community.

[21] While certainly Mr. Welton's capacity to pose a threat to others has not been entirely eliminated, it is our view that all in all he may be more of a risk to himself than he poses to others. Although given his history Mr. Welton's progress will not be entirely even or uninterrupted, we concluded to absolutely discharge him as at the time of this hearing we did not consider him a significant threat of serious physical or psychological crime.

[22] We trust that Mr. Welton has learned something from his recent experiences and that those experiences will be an encouragement to avoid future criminal justice entanglements.

Following his discharge, his treating psychiatrist wrote to the Duncan RCMP Detachment what can only be taken as a warning letter including the comment, "He was discharged against medical advice." Mr. Welton received no assistance with or treatment for his mental health or drug use issues from the time of his discharge to the time of his death.

March 1, 2009, Mr. Welton called 911 and the following conversation took place:

9-1-1 Operator:	9-1-1 Emergency, do you need Police, Fire, and Ambulance?
D. WELTON:	Yeah um is this uh 9-1-1, the dispatch?
9-1-1 Operator:	Yeah do you need the Police, the Fire or the Ambulance?
D. WELTON:	The police are here. I need protection. This is war dog flight squadron leader and I comply you must get my flight squadron airborne! Now!
9-1-1 Operator:	Hello? Hello?

Note
The police were not there and Mr. Welton's second statement was delivered in what sounded like a desperate shriek.

The 911 operator attempted without success to reconnect with Mr. Welton. In accordance with established practice, the operator then dispatched the police. The police officers dispatched knew Mr.Welton, his residence and his history. The officers met and developed a plan and approach. An ambulance was called to standby. It was determined they would establish a secure perimeter and have Mr. Welton come out of his trailer to be arrested under the *Mental Health Act*.

The watch commander arrived late and knew nothing of the plan that had been discussed. He determined that he would enter the trailer as he thought Mr.Welton had calmed down. Other officers entered behind the watch

commander. One of those officers determined to taser Mr. Welton. Mr. Welton reacted to the taser by grabbing a kitchen knife and moving toward the watch commander.

The watch commander wanted to retreat, but found his exit blocked by his fellow officers who were wedged in the small door way of the trailer. He fired his service pistol at Mr. Welton. The watch commander looked again to escape. The other officers still blocked his retreat and he fired two more shots at Mr.Welton. Mr.Welton suffered two gunshot wounds.

The ambulance standing by was called into the scene. The attendant and driver provided aid to Mr. Welton and transported him to the Cowichan District Hospital where despite the efforts of the doctors and staff, Mr. Welton succumbed to his wounds.

Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

The following recommendations have been formulated by the evidence presented to we the jury. In this inquest into the death of Derek Wayne Welton it is our opinion that he could have been better served by the resources within the province of British Columbia.

JURY RECOMMENDATIONS:

To: North Cowichan/Duncan RCMP Detachment, RCMP E Division

1. We recommend the RCMP review their training strategies in dealing with mental health situations. This review should include the use of available psychiatric resources such as B.C. Mental Health and Addiction Services, and the Forensic Psychiatric Services Commission. These resources are to be accessed when required at an incident.

2. We recommend the North Cowichan/Duncan RCMP undertake a review of their tactical team strategies regarding any future incidents of this nature. We also recommend tactical discussions at the scene include entry and exit strategies be discussed beforehand and wholly understood by all parties.

   Coroner's Comment:

   The jury heard evidence indicating that there was no consultation between police and Mental Health prior to or at the time of the incident. Mr. Tanner of the Psychiatric Unit of the local hospital testified that he knew Mr. Welton well and if called he could have assisted.

   The jury heard evidence the tactical plan here was changed by the watch commander without consultation or coordination.

To: British Columbia Review Board

3. We recommend that the British Columbia Review Board notify local agencies such as the RCMP, BC Mental Health and Addiction Services, and local hospital authorities when an absolute discharge is granted against medical advice.

To: Minister of Health

4. Due to the apparent lack of facilities for psychiatric patients in the province and in particular in the Cowichan Valley as indicated by the B.C. Review Board in their decision concerning Mr. Welton of December 15, 2008, we strongly recommend an extensive review of the resources currently available.

To: Duncan Mental Health, Director

5. We recommend an outreach program be developed in Duncan styled on the Victoria model. Local Cowichan Valley patients would greatly benefit from such a program.

To: North Cowichan/ Duncan RCMP, Duncan Mental Health, Forensic Psychiatric Services Commission

6. It is our understanding that meetings between the RCMP and Mental Health occur on an irregular basis. We recommend an increase in the frequency of these meetings to cover regular and/or emergent issues.

To: B C Mental Health and Addiction Services/ Forensic Psychiatric Services Commission

7. We recommend more than one forensic psychiatric nurse be available in the Cowichan Valley.