



VERDICT AT CORONERS INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST PURSUANT TO
SECTION 38 OF THE CORONERS ACT, [SBC 2007] c 15, INTO THE DEATH OF

Rintoul

SURNAME

Daniel Peter

GIVEN NAMES

An Inquest was held at The Burnaby Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates: Oct. 31-Nov. 4, 2022; Nov. 7-Nov. 8, 2022

before: Susan Barth, Presiding Coroner.

into the death of Rintoul Daniel Peter 38 ☒ Male ☐ Female
(Last Name) (First Name) (Middle Name) (Age)

The following findings were made:

Date and Time of Death: November 10, 2016 1529
(Date) (time)

Place of Death: 2830 Bentall St., Vancouver, BC
(Location) (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Gunshot wounds
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 8th day of November AD, 2022

Susan Barth
Presiding Coroner's Printed Name

Susan Barth
Presiding Coroner's Signature



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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:

JURY RECOMMENDATIONS:

To: Ministry of Mental Health and Addictions

1. Review process regarding how appointments to mental health clinic are scheduled for inpatients; recommend appointment scheduled prior to discharge from hospital.
2. Review hospital discharge criteria to ensure support person(s)/network is established prior to discharge, (e.g. Friend, family, family physician, mental health clinician.)
3. Review process for development of rapport and goals of care in the context of timing and duration of patient visits. Consider processes for referral to alternate service provider if rapport is not established in a reasonable time.

To: Chief Firearms Officer, Province of British Columbia

4. Review policies and requirements for the implementation of emergency preparedness procedures in establishments that sell firearms and ammunition.
5. Review (provincial) policies to ensure impenetrable storage and display of firearms and ammunition.

To: Vancouver Police Department

6. Review the requirements to communicate when a police officer loses control of a weapon including the status of such weapon (loaded vs unloaded).
7. Review the provisions for Mental Health support available to all police personnel; ensure timely access to mental health care for VPD personnel affected by incidents.