BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

VERDICT AT CORONER'S INQUEST

File No. 2007:0562:0069

An Inquest was held at Supreme Court of British Columbia, in the municipality of Vernon

In the Province of British Columbia, on the following dates November 12-14, 2008

before Mr. Norm Leibel, Presiding Coroner,

into the death of KLIM CHRISTOPHER PAUL 24 (Age) ☒ Male ☐ Female

And the following findings were made:

Date and Time of Death: December 27, 2007, at 1321 hours

Place of Death: Private Residence (Location) Vernon, BC (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Exsanguination

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Gunshot wound to chest

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 14th day of November AD, 2008.

MR. NORM LEIBEL
Presiding Coroner's Printed Name

Presiding Coroner's Signature

BRITISH COLUMBIA

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST INTO THE DEATH OF

FILE NO.2007:0562:0069

KLIM	CHRISTOPHER PAUL
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Norm Leibel

Inquest Counsel: Chris Godwin

Court Reporting/Recording Agency: Verbatim Words West Ltd.

Participants/Counsel: Ms. Helen Roberts, counsel for Attorney General of Canada/RCMP
Mr. James Cotter, counsel for father and stepmother

The Sheriff took charge of the jury and recorded 9 exhibits. 21witnesses were duly sworn in and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as presented to the jury at the inquest. The summary and my comments respecting the recommendations are only provided 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.

Christopher Paul Kim's history included mental illness with a diagnosis of schizophrenia in 2002, several suicide attempts and a number of hospital care settings as recent as August 2007. Christopher was reluctant to accept he was mentally ill. He never accepted the diagnosis of schizophrenia. He was extremely opposed to hospital care so it was decided that he would be treated and cared for from his home on the condition that he take his medications and attend appointments as required. Assistance was provided by a mental health team including a psychiatrist, case manager and community support worker. There was a progression of increased resistance to the diagnosis, intervention and compliance with medication treatment. As a result, Christopher ultimately refused to attend for any further medication, his mental state deteriorated further, and self harm indicators were escalating.

On December 18, 2007, a Director's Mental Health Warrant was issued and forwarded to the Vernon RCMP the next day providing them authority to apprehend Christopher and deliver him to the Vernon Jubilee Hospital. RCMP attended to Christopher's residence that same day however did not get any response. They gained entry with assistance of the manager into the apartment however Christopher was not at home. Officers noticed several kitchen knives in open view throughout the apartment. The warrant for Christopher's apprehension was entered into the RCMP computer and details placed onto the local Detachment's information pass-on system. Christopher's previous experience with the RCMP had been confrontational.

On December 27, 2007, a family member, now aware of the warrant to apprehend, contacted mental health to report they had recently met Christopher and noted evidence of self harm and just spoken with him on the telephone at his apartment. This information was passed along to the RCMP.

The RCMP felt this was a priority, emergency situation. Christopher had a history of suicide attempts, family had seen evidence of self harm including the most recent cuts to his face, was in possession of knives, and was at home. It was felt that Christopher was likely in the process of suicide and needed medical assistance immediately. A team of Officers gained entry to Christopher's apartment and found him alive in the bedroom. Christopher was brandishing a knife in each hand demanding that the Police leave. Police were directing him to drop the knives. Christopher was non compliant and his behavior was interpreted by the Police as threatening to their safety. The taser was deployed with little effect. Christopher came out of the bedroom toward the Police Officers brandishing the knives. Three shots were fired at Christopher and he fell to the floor fatally wounded.

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Pursuant to Section 38 of the Coroner's 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: The Minister of Health and Provincial Health Regions

1. That a Provincial policy be developed regarding the apprehension of patients and/or clients with mental illness history when requesting police assistance.

   Coroner's Comments: The jury heard evidence from Mental Health witnesses that there is no standard protocol in place; once Police were notified in this circumstance of the warrant to apprehend, the matter was basically turned over to them pending apprehension.

2. Mental Health Warrants forwarded to the local police for execution will include an information check list, including but not limited to the following.

   i. Details and descriptors of the patient and/or client.
   ii. Known residences or potential locations to be found.
   iii. Description of mental illness history, behavior and potential response to authority.
   iv. History leading to the issuance of the Mental Health Warrant.
   v. Mental Health contact person information.
   vi. Other comments.

   Coroner's Comments: The jury heard evidence from both Mental Health and Police witnesses who acknowledged the value of detailed information sharing and communication in these types of circumstances.

3. When police are contacted relative to a missing patient and/or client not subject of a warrant and with a mental illness history, the same complete information checklist is forwarded to the local police at the time assistance is requested.

   Coroner's Comments: same as recommendation #2.

4. Upon forwarding a Mental Health Warrant to Police the Mental Health contact person shall notify patient's and/or client's contact family members.

   Coroner's Comments: The jury was presented with evidence that demonstrated the need for and assistance that family can provide to Mental Health and Police agencies that will assist bringing that client/patient to medical care.

5. After forwarding a Mental Health Warrant to Police, the warrant shall be followed up by a Mental Health contact person with Police every 24 hours or until the patient has been apprehended.

   Coroner's Comments: The jury was presented with evidence that demonstrated a need for the Mental Health agency to work with the Police on an ongoing basis through to apprehension of the client and or patient.

6. Permanent housing made available for patients with long term mental issues and suicidal tendencies that would provide total supervision in a safe environment.

   Coroner's Comments: Christopher Klim was a person with long term mental health issues, history of suicide, and needed to be medicated in order to maintain a sustainable life. He was placed in an apartment alone where he now was in a position to refuse intervention and compliance with medication treatment. This situation and circumstance ultimately led to his unnatural death.

To: The Minister of Public Safety and Solicitor General

7. That a minimum standard operational and case management policy be developed for all city, municipal and RCMP officers in the province of British Columbia regarding the apprehension of patients and/or clients with mental illness history relative to the following.

   i. Execution of Mental Health Warrants.
   ii. Requests for apprehension or assistance to locate missing patients and/or clients with mental illness history from hospital settings or otherwise.
   iii. More knowledge or training for managing mental health patients.

   Coroner's Comments: The jury heard evidence from the different Police Officer witnesses that each applied their own individual investigative experience handling mental health situations. There was no minimum standard investigation identified. Aside from the initial inquiry regarding Christopher's whereabouts by Police and entry onto the Police computer system, no active investigation was undertaken to locate him. In this circumstance, the longer Christopher refused to take his medication and was not apprehended to ensure medical/medication intervention, the more his mental state deteriorated.

   Mental Health training currently provided to the Police witnesses is limited. Value of training was highlighted.

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