BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

VERDICT AT INQUEST

File No.: 2009:1006:0094

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

in the Province of British Columbia, on the following dates July 25 - 29, 2011

before Marj Paonessa, Presiding Coroner,

into the death of HUGHES Jeffrey Scott 48 ☒ Male ☐ Female
(Last Name, First Name Middle Name) (Age)

and the following findings were made:

Date and Time of Death: October 23, 2009 at approximately 0735 hours

Place of Death: 531 Selby Street (Location) Nanaimo, BC (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Massive Blood Loss

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Multiple Gunshot Wounds.

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 29th day of July AD, 2011.

Marj Paonessa
Presiding Coroner's Printed Name

M Paonessa
Presiding Coroner's Signature

HUGHES	JEFFREY SCOTT
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Marj Paonessa
Inquest Counsel	Rodrick MacKenzie
Counsel/Participants:	David Kwan/Attorney General of Canada
	Douglas Christie/Russell Hughes
	Raj Samtani/Dr. K. Phillips

Court Reporting/Recording Agency: Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded 6 exhibits as entered. Twenty witnesses were duly sworn and testified.

PRESIDING CORONER'S SUMMARY:

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, if any, 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.

The jury heard that in the early morning hours of October 23, 2009, Jeffrey Scott Hughes was assaulted by his neighbours over a noise complaint at his Selby Street apartment in Nanaimo over a noise complaint. This resulted in Mr. Hughes returning to his apartment and turning his music up very loud. The apartment manager was called and he subsequently contacted the RCMP. The first officers arrived at 05:42 am and was met by the apartment manager who told them that Mr. Hughes possibly had knives in his apartment and had a mental illness. They were not familiar with Mr. Hughes and no relevant information was available to them on their computer system. Backup was requested and another officer attended to the location.

It was dark and raining. There was some artificial light at the location. As the officers approached Mr. Hughes' apartment door, they observed fresh blood droplets on the concrete walkway in front of his apartment. A radio request for an ambulance to stage nearby. The officers attempted to communicate with Mr. Hughes through his closed door. He responded by yelling obscenities and refusing to come out of the apartment. As a result the police were unable to address the noise complaint or determine if Mr. Hughes was injured. Loud music was heard being turned on and off sporadically and objects were heard being moved within the apartment. Attempts were made to contact him by phone; however, he refused to answer. Officers remained at his doorway attempting to engage Mr. Hughes in conversation for several minutes as more officers arrived on scene. Eventually, Mr. Hughes advised the police he would not come out and he would shoot them if they entered his apartment.

At 6:40 a.m., the decision was made to call out the Emergency Response Team (ERT) along with negotiators and a police dog. While awaiting the ERT members, officers on scene proceeded to contact all other residents in the building to stay inside their apartments until it was safe to leave. The occupants of the house immediately across the street were contacted and advised to stay at the back of the home. RCMP Dispatch contacted the Psychiatric Unit at the local hospital and explained to nursing staff that Mr. Hughes was refusing to exit his apartment and was threatening to shoot officers. The staff initially refused to share any information about Mr. Hughes due to privacy issues. A call to the Crisis Response Team telephone line was met with an answering machine indicating

that no one was available to respond until 8:00 a.m. A message was left to call RCMP Dispatch immediately regarding the situation with Mr. Hughes.

At approximately 6:51 a.m., Mr. Hughes suddenly opened the door of his apartment. Officers were situated just outside his door and observed what they thought was a handgun in his hand. This was later determined to be a loaded marine flare gun. The jury heard evidence that Mr. Hughes pointed the flare gun at one of the officers who retreated to the far end of the building. Mr. Hughes went back inside his apartment and at 6:56 a.m., he opened the apartment door again and began to walk down the walkway towards the back of the building. He was wearing headphones and was holding the flare gun with both hands out in front of him at shoulder length pointing it in various directions.

The officers commanded Mr. Hughes to drop the flare gun, but he continued to walk towards the back of the building. He then turned and began to walk down the driveway towards Selby Street. The officers again commanded Mr. Hughes to drop his weapon. Evidence from the officers indicated that Mr. Hughes turned and pointed the weapon towards them as he was walking away from them. At 6:57 a.m., officers discharged their weapons and Mr. Hughes collapsed at the front corner of the building. ERT officers arrived on scene at 7:13 a.m., and secured Mr. Hughes' flare gun and cleared his apartment. The ambulance was then summoned to attend and Mr. Hughes was determined to be without vital signs.

HUGHES	JEFFREY SCOTT
SURNAME	GIVEN NAMES

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: Minister of Health
Province of British Columbia, and

Commanding Officer
'E' Division
Royal Canadian Mounted Police, and

B.C. Association of Chiefs of Police

1. Steps be taken to develop a 24-hour link to share mental health information between Ministry of Health and Provincial and Federal police agencies.

Coroner's Comments: The jury heard evidence that the police were unable to gather any relevant personal or medical information from medical staff at the hospital with respect to Mr. Hughes as this incident unfolded. They also heard that police officers throughout British Columbia respond to escalating situations such as this incident involving a person with mental health issues on a frequent daily basis.

To: Attorney General for Canada, and

Minister of Public Safety and Solicitor General
Province of British Columbia

2. Duty to Account reporting be completed in a more timely fashion to reduce inconsistencies.

Coroner's Comments: The jury head that the mandatory Duty to Account reports submitted by the police officers were not received in this case for some time after this incident occurred.

To: Minister of Public Safety and Solicitor General
Province of British Columbia

3. Support the recommendations of the current reading of Bill 12.

Coroner's Comments: The jury was made aware through the evidence of the development of the Independent Investigations Office which will be conducting police-involved death investigations of this type in the future in British Columbia.

To: Commanding Officer
'E' Division
Royal Canadian Mounted Police, and

B.C. Association of Chiefs of Police

4. Provide Real Evidence audio/visual equipment to policing agencies.

Coroner's Comments: The jury heard in evidence about the existence of pocket and/or lapel video cameras which have the ability to record communication and actions of police officers during the course of their duties.

To: Commanding Officer
'E' Division
Royal Canadian Mounted Police

5. Have ERT and Negotiators on each police watch.

Coroner's Comments: Evidence was presented that ERT members and negotiators respond to calls from their homes in all areas across Vancouver Island. Therefore, the response time may be lengthy in some cases.

Marj Paonessa
Presiding Coroner