Ministry of Public Safety and Solicitor General

VERDICT AT INQUEST

File No.: 2010-0270-0002

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

in the Province of British Columbia, on the following dates April 2 – 4, 2012

before Liana Wright, Presiding Coroner,

into the death of Wilcox, Matthew John (Last Name, First Name Middle Name) 39 (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: January 10, 2010 20:13

Place of Death: Lions Gate Hospital (Location) North Vancouver, British Columbia (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Gunshot Wound

DUE TO OR AS A CONSEQUENCE OF

b)

Antecedent Cause if any:

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: Mental Illness; Atherosclerotic Cardiovascular Disease; Respiratory Depression

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

The above verdict certified by the Jury on the 4th day of April AD, 2012.

Liana Wright
Presiding Coroner's Printed Name

Presiding Coroner's Signature

WILCOX	Matthew John
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Liana Wright
Inquest Counsel Rodrick MacKenzie
Counsel/Participants: Helen Park/Attorney General of Canada

Court Reporting/Recording Agency: Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded 3 exhibits as entered. Sixteen 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 Mr. Wilcox had a history of bipolar disorder and substance abuse issues. His psychiatrist testified that Mr. Wilcox had sustained a severe head injury in a motor vehicle incident in 1999 which left him with mental difficulties. Mr. Wilcox's spouse testified that he had recently lost his job and was feeling quite stressed. On the morning of January 9th, 2010, she arrived home and noticed that he had been drinking. An argument ensued and he left their home. She reported that he had not taken his medications that morning.

On the afternoon of January 9th, 2010, North Vancouver RCMP responded to a 911 call in which a civilian reported seeing a Toyota Matrix collide into an unoccupied parked vehicle and leave the scene. Police caught up to the vehicle as it was being driven eastbound on Mount Seymour Parkway, approaching Deep Cove Road. From the license plate provided by the civilian caller, police believed they were dealing with Matthew John Wilcox, with whom they had had a past violent interaction. The officer following the Matrix recalled dealing with Mr. Wilcox at a past incident and recalled threats that he had made at that time to shoot police. The officer activated his lights and sirens and stopped the vehicle at the northeast corner of the intersection of Deep Cove Road and Strathcona Road. Both the officer and Mr. Wilcox exited their vehicles. Mr. Wilcox walked towards the back of his vehicle. The officer, who had drawn his gun, began to approach Mr. Wilcox. He recalled shouting 'Police, you're under arrest! Get on the ground!' Mr. Wilcox got onto all fours and the officer believed he was going to comply. Mr. Wilcox then looked up at the officer, got up and began to advance towards him with a quickened pace. The officer began to walk backwards away from him, continuing to shout commands. He recalled seeing Mr. Wilcox shove his right hand into his pocket and then seeing a black object being retrieved. The officer shot Mr. Wilcox. He was handcuffed with the assistance of another officer who had arrived on scene. The incident was witnessed by several civilian witnesses who recalled hearing and seeing the officer give verbal commands to Mr. Wilcox. They testified that Mr. Wilcox was failing to comply with the orders when he was shot by the police officer. It was later determined that Mr. Wilcox had been retrieving his cell phone out of his pocket. He told the officer who shot him that he was intending to text his spouse.

WILCOX	Matthew John
SURNAME	GIVEN NAMES

Mr. Wilcox was transported by paramedics to Lions Gate Hospital. He was taken to the operating room for abdominal surgery. Mr. Wilcox died the following day on January 10th, 2010 at 2013 hours.

His family and friends were devastated that they had not been allowed to see or visit with him prior to his death during the hospitalization.

An autopsy was conducted which revealed a single perforating gunshot wound of the abdomen. A significant finding of a focal atherosclerotic lesion in one coronary artery was reported. There were no significant toxicology results that contributed to death.

The pathologist testified that the gunshot wound Mr. Wilcox sustained would not have been life-threatening and that most people would have been expected to survive this injury. He testified that Mr. Wilcox's significantly blocked artery put him at risk for sudden death and that the added physiological and psychological stresses of the gunshot wound would have contributed to the stress on the heart.

Vancouver Police investigated the circumstances of this police shooting and the investigating officer reported that no charges had been recommended to Crown Counsel.

WILCOX	Matthew John
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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:

1) To Officer in Charge, RCMP 'E' Division:
That the current 'Operation Skills Training Program' for RCMP officers be expanded to include Crisis Intervention and De-escalation training techniques when dealing with persons who are mentally ill. Such training techniques should be reviewed on a regular basis.

   The jury heard from one police officer that there is no specific training offered on how to deal with mentally ill persons, with the exception of training provided on Mental Health Act apprehensions and Excited Delirium. The jury heard from another officer that de-escalation techniques were not part of training given at RCMP Depot.

2) To Officer in Charge, RCMP 'E' Division:
That liaison teams comprised of a police officer and a mental health professional be available at all times to respond to calls involving a mentally ill individual to assist in de-escalating the situation, and providing mental health assessment and assistance.

3) To Officer in Charge, RCMP 'E' Division:
That police officers be required to call out: "Stop or I will shoot." to inform individuals of intent to shoot during armed apprehensions.

4) To Officer in Charge, RCMP 'E' Division:
That any situation involving an individual with a history of violence towards police or others, only be assigned to a team of two police officers. Such teams should be equipped with intermediate weapons.

   The jury heard that the officer involved in this shooting was trained in taser usage; however, his certification had lapsed. He further testified that the situation was not appropriate for taser deployment (an intermediate weapon) because he had no fellow officer providing lethal coverage. .

5) To Officer in Charge, RCMP 'E' Division:
That witnesses be interviewed in a prompt manner at the scene of an incident, and basic human needs be provided for, including access to water, food, washrooms, and legal counsel, and timely contact be made with employer or immediate family.

   The jury heard from witnesses to the incident that they were escorted onto a bus and were kept waiting for a long period of time with no food and no ability to contact their families.

6) To Officer in Charge, RCMP 'E' Division:
That police officers on duty be equipped with audio-video recording devices.

The jury heard that the officer involved in this shooting did not have any recording devices on his vehicle to capture footage of encounters.

7) To Vancouver Coastal Health Authority
To Officer in Charge, RCMP 'E' Division:
That when an individual is arrested by police and is brought to hospital and admitted, that all efforts are made to accommodate family visitation as soon as possible.
That family members be promptly informed when person in custody is admitted to hospital.
That family members be informed when an individual is released from custody while in hospital.

8) To Vancouver Coastal Health Authority:
That the Fatality Review Committee of Lions Gate Hospital investigate Mr. Wilcox's chart to consider pain management and observations of vital signs, with specific attention to respiratory depression for extended periods.

The jury heard that Mr. Wilcox had suffered some respiratory depression while hospitalized that was believed to be due to the use of self–administered opiates while on an intravenous pump (PCA: Patient Controlled Analgesia). The pathologist reported that patients can manage their own pain control, but it is programmed so that patients cannot overdose themselves.. He further testified that the opiate would not have strained the heart, but would in fact decrease the strain on the heart due to its effects on lowering blood pressure. The pathologist reported that it appeared that Mr. Wilcox was sensitive to opiates.