Ministry of Justice
Coroners Service
Province of British Columbia

File No. :2012:0381:0049

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

BAYRAMI	**Mehrdad**
SURNAME	GIVEN NAMES

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

in the Province of British Columbia, on the following dates February 9-16, 2016

before: Dr. D. Kelly Barnard, Presiding Coroner.

into the death of Bayrami (Last Name) Mehrdad (First Name) (Middle Name) 48 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: November 18, 2012 19:58

Place of Death: Royal Columbian Hospital (Location) New Westminster, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Complications arising from gunshot wound

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 16 day of February AD, 2016

Dr. D. Kelly Barnard
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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

BAYRAMI	Mehrdad
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Dr. D. Kelly Barnard
Inquest Counsel:	Mr. R.H. MacKenzie
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Mr. D. Butcher, Mr. D. McKnight, Mr. D. Pilley

The Sheriff took charge of the jury and recorded 7 exhibits. 37 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.

Mehrdad Bayrami died at the Royal Columbian Hospital on November 18, 2012. He was 48 years old.

The jury heard that Mr. Bayrami was an active and generally physically healthy man who most recently worked as a transit operator. He had suffered from episodes of depressed mood and problematic behaviour over many years, associated with relationship difficulties and family discord. He sought mental health assistance minimally and intermittently from family physicians.

The dissolution of a long term romantic relationship in August of 2012 was associated with severe depressive symptoms, including agitation and insomnia for which he sought medical care from his family doctor. The doctor testified that he saw Mr. Bayrami very frequently during the three months before his death. In addition to a work related shoulder injury, Mr. Bayrami was assessed to have a severe depression and was started on medications on August 10, 2012, to treat the depression and the associated symptoms. He was on medical leave from his workplace during this time because of the shoulder injury. The doctor noted that Mr. Bayrami was obsessed by his relationship issues, but that he was not psychotic. Mr. Bayrami did report suicidal thoughts; however, the doctor specifically assessed this risk and felt that it was appropriately managed with the regular visits and the medication regime. The doctor testified that he did not consider that referral for counselling was indicated. At his last visit to the doctor on October 23, 2012, Mr. Bayrami was reported to be compliant with treatment and to be responding well to the medication with improvement in both conditions. He was deemed fit to return to work as a bus driver.

Throughout this same period, the relationship issues with his ex-partner escalated. She made multiple reports to the police that Mr. Bayrami was engaged in threatening behaviours, including intrusion into her home, and active tracking of her movements. She reported that he was attempting to contact her as many as sixty times a day. Mr. Bayrami also filed complaints about her, including alleging a theft. On October 15, 2012, the file came to a constable in the domestic violence unit at Richmond RCMP who testified that, through investigation including a review of the pattern of behaviours, she had determined that the situation was high risk for violence. Mr. Bayrami was arrested twice for criminal harassment; first on September 30, 2012, at which time he was released on a Promise to Appear; and the second time on October 26, 2012, at which time he was remanded.

On October 29, 2012, Mr. Bayrami was transferred to the Surrey Pretrial Centre. Prior to his court appearance, Mr. Bayrami was assessed by the physician in the facility. The doctor reported that Mr. Bayrami was noted to be depressed but that he was not suicidal or psychotic. His antidepressant medication was ordered to be given while at the Pretrial Centre. The doctor testified that although Mr. Bayrami may have missed a day or two of his medication, this was not uncommon and would not be clinically significant.

On October 31, 2012, Mr. Bayrami appeared before a judge who released him on bail with an order to attend court on November 13, 2012. The bail conditions specifically included instructions that Mr. Bayrami was not to approach his ex-partner or a number of her family members and friends. Mr. Bayrami's ex-partner testified that despite the bail conditions, she had ongoing concerns about Mr. Bayrami's behaviour. She thought that he was continuing to follow her.

On November 8, 2012, Mr. Bayrami's ex-partner arrived for her scheduled work day at the Starlight Casino in New Westminster at approximately 5:40 am. Before she could enter the building, she was accosted in the parking lot by Mr. Bayrami who had a hand gun. He pointed the gun at her demanding that she go with him so that they could talk. The jury saw video footage from the parking lot security cameras that showed Mr. Bayrami attempting to coax his ex-partner into a vehicle, and at one point firing his gun into the passenger door of the vehicle as she sat in the passenger's seat. After multiple attempts, Mr. Bayrami managed to get her into the car and began to drive away out of the field of the video surveillance. His ex-partner testified that she tried to stop the car by using the brake, and then she opened the door and fell onto the ground. Mr. Bayrami also left the vehicle and as it was still moving, it hit the wall of the parking lot. He then went around the car and grabbed his ex-partner by the sweater and pulled her onto the street on the west side of the casino. Throughout this time, she reports that he was accusing her of lying and telling her that he would not go back to prison. As the police arrived at the scene Mr. Bayrami put the gun to his head and told his ex-partner that he was going to kill himself

because of her. They continued to proceed down the street and once again were picked up by video surveillance. Mr. Bayrami pushed her in front of him holding her sweater as the police addressed them over a loud hailer. The ex-partner testified that he let her go and continued to hold the gun to his own head. She tried to convince him to put the gun down and then she followed the police instruction to leave Mr. Bayrami and come to them. Three officers led her to an area of safety and she was then taken to the hospital for assessment and care of a minor injury to her forehead.

The officers attending the incident confirmed the outline of events described above. The Municipal Integrated Emergency Response Team (ERT), a joint unit of the Delta, New Westminster and Abbotsford police forces, was mobilised in this incident. This team is no longer active and the responsibility for this function now rests with the Lower Mainland ERT provided by the RCMP. The members of the team testified that they had regularly trained together, spending several days each month on ERT-related activities including simulation exercises and weapons training.

New Westminster constables were the first on the scene and one of them began to address both parties on the loud hailer, instructing Mr. Bayrami to put the gun down and let the woman go. This officer continued to maintain verbal contact as the ERT members arrived. They established positions in armoured vehicles at approximately 50 metres to the east and west of Mr. Bayrami's position, and a three person sniper team was assigned to the containment area to the to the south, behind some brush. A three person team was assigned to contain the area to the north on the upper level of a parking lot. After the woman was moved to safety, the New Westminster constable continued to engage Mr. Bayrami over the loud speaker. Mr. Bayrami had by this time discarded his cell phone, was sitting on the pavement, and was responding by nodding or shaking his head. At 0842, a cell phone was delivered by a police bomb disposal robot and accepted by Mr. Bayrami. This robot also was equipped with a video camera that recorded images only, as it had no microphone for sound recording. This video was presented at inquest and covered the incident from that time forward. Due to a technical limitation, only the police side of the cell phone conversations that ensued were recorded. The originally responding constable continued to talk with Mr. Bayrami. The constable testified that during their phone conversation Mr. Bayrami continued to insist that he needed to talk to his ex-partner first and that he would then talk to police. The constable reported that Mr. Bayrami stated that the police were safe, that he was not a bad man, that he would be leaving in a body bag, and that he would be taking his own life that day. He then hung up the phone. At 09:46, one of the negotiators from the ERT who had been there supporting the New Westminster constable to that point took over the negotiations and continued to attempt to engage Mr. Bayrami.

Over this period, an escalation plan was put into place by the site commander. It was decided that a perimeter of 20 metres around Mr. Bayrami would be established and that action would be taken if he breached that area. The incident commander indicated that the concern about the breach was that, given the relatively open area, Mr. Bayrami might be able to escape containment. The plan was communicated by radio to the officers at the scene. The instructions were for the initial use of non-lethal means, including Arwen guns that fire large plastic projectiles, dogs, and flash devices. The plan called for use of lethal force in the event that those measures failed to contain him. The tactical team members testified that the negotiators did not warn Mr. Bayrami about the perimeter and the consequences of his moving outside that area. It was explained that it is not general procedure to make these tactical decisions known to the subject in order to avoid purposeful breach.

At 10:38, the video shows Mr. Bayrami standing up and moving around in the area. He held the gun in his hand and pointed it at his head and chest. He ejected the ammunition clip and signaled to officers that he had only one bullet. He moved along the path towards the stationed armoured vehicle to the west of his position with his gun arm extended above his head. At 10:41, the Arwen gun was fired. Mr. Bayrami flinched slightly and moved backwards, his arm with the gun arcing downwards towards the ground. Almost simultaneously, a flash grenade was released and live shots were fired. Mr. Bayrami fell to the ground. The gun was still in his hand and dogs were deployed to disarm him. Paramedics then attended and he was transferred to hospital.

The jury heard that response to incidents such as these involves three components; command, tactical and negotiations. An Inspector from the New Westminster Police was designated as commander and set up a command centre at the police station, a constable with several years of ERT experience was designated as acting sergeant and was the site commander responsible for the tactical component. The negotiators were police constables who had received specific training in negotiations.

Officers testified that there were significant challenges in accessing professional support for negotiations. Although the police department had an informal list of psychologists who could be called upon, there was no formal arrangement for availability. The first psychologist contacted testified that she declined to attend as she was scheduled to provide a training seminar that day. She eventually did provide some advice by telephone; however, there were no clinical records associated with this service and she did not recall the details of the encounter. Another psychologist was also contacted and provided some telephone advice. An unsuccessful attempt was also made just as the incident was ending to contact a psychiatrist through the emergency department at the Royal Columbian Hospital, although no formal arrangement for accessing such services was in place.

The site commander did not know the exact number of officers deployed, but estimated it to be approximately 27. Two armoured vehicles were deployed with a total capacity of eight to ten officers each. The remainder of the team was positioned behind the vehicles or on the slopes overlooking the site under cover of brush. The video of the incident showed officers coming out from cover and walking to and from the vehicles several times. As the incident was prolonged, officers were rotated through assignments. The negotiations team was in one of the armoured vehicles with a sniper situated in the turret.

The jury heard from 17 of the officers directly involved and there were some inconsistencies in accounts. The officer who deployed the Arwen gun testified that he was aware of the escalation plan as it had been transmitted over the radio. Although the site commander said that he issued a specific order to the deploy the Arwen, the officer stated that he did not receive a command and did so on his own initiative when he saw Mr. Bayrami breach the designated perimeter. The officer who deployed the flash grenade testified that it was an approach most commonly used in buildings and other contained situations where the loud noise and flash is disorienting to the subject. He stated that it was difficult to accurately place the device across a large distance and that in this circumstance the grenade fell within 20 metres from Mr. Bayrami.

The officer who fired the lethal shot was stationed behind one of the armoured vehicles to the east of Mr. Bayrami. He testified that he had been involved with the incident from approximately 06:00 onwards. He was fully aware of the tactical plan. He was assigned lethal overwatch and was armed with a Stag Arms AR15 rifle. He described that it was his perception that when Mr. Bayrami stood up and began to move, that he was advancing towards his position. He did not note any reaction by Mr. Bayrami to the firing of the Arwen gun. He stated that he saw Mr. Bayrami's arm lower, resulting in the gun being pointed at the officers' position and that was when he fired. He stated that he did not receive a command to fire and this was corroborated by the testimony of the site commander who stated that no such order was made. At the time of the incident, the officer had been in the police force for 44 months and had been on the ERT for approximately 7 months. This incident was his first barricade situation. His training had consisted of the usual police training at the Justice Institute of BC and a further 200 hours in ERT-specific training with his ERT colleagues

Mr. Bayrami was alert and oriented when placed in the ambulance for transfer to the Royal Columbian Hospital at 10:53 am. Intravenous lines were started during transport and his condition deteriorated prior to arrival, with decreased level of consciousness and a fast heart rate. On arrival at the hospital at 11:05, he was assessed and treated with antibiotics, fluid and blood transfusions by the trauma team who had assembled in preparation for his arrival. On examination, the trauma surgeon noted a gunshot wound through his upper abdomen. There was also a bruise on his abdomen that he testified was consistent with an Arwen strike, and injuries

consistent with dog bites on his legs. Emergency surgery was performed at 11:45. Extensive trauma was identified, necessitating the partial removal of liver, gallbladder, right kidney, removal of section of colon, repair of duodenum and vena cava (a large blood vessel in the abdomen). As is the usual practice in these cases, because of extensive generalized bleeding, and contamination of the abdomen with bowel contents, surgical sponges were left in place and drainage tubes were inserted. Mr. Bayrami required multiple blood transfusions and medications to maintain his blood pressure. At 1335, he was discharged to the Intensive Care Unit (ICU). He was observed there for 24 hours and as his condition was unstable and there was concern about ongoing bleeding, he was taken back for a second operation on November 10th. Packing from first operation was removed, more damaged liver tissue was removed, a patch was applied to the repaired area on duodenum, more colon was removed, and injury to the spleen caused by the packing was repaired. He was discharged back to the ICU in stable condition with a feeding tube in his small bowel, a nasogastric tube to drain his stomach, and three surgical drains placed by the traumatised areas of his liver, spleen and duodenum.

His condition was reported to be stable in the ICU on November 11th and the endotracheal tube that had been in place to support his breathing was removed and antibiotics were discontinued. The nurse's notes indicate that he was talking. On November 12th, his condition deteriorated and he was noted to be confused and agitated and was diagnosed with delirium. Delirium is a state of mental confusion common in hospitalized patients. It develops quickly and usually fluctuates in intensity. There are many causes including infection, medications and metabolic disturbances. Mr. Bayrami required sedation and replacement of the endotracheal tube. On November 13th, the records indicate that his delirium continued with agitation, and no purposeful movements. He was noted to have a fever of 38.4 degrees C in morning and evening. The surgeon testified that this was not unusual post-operatively, and that the fever and delirium could be due to multiple causes. Blood, sputum and urine cultures were sent and these were eventually reported as negative; however, he had been on antibiotics for three days prior to this testing making it less reliable. No further antibiotics were administered throughout the hospital stay. On November 14th, the endotracheal tube was removed. Mr. Bayrami was conversant but continued to be confused at times; for example, the nursing notes indicate that he was requesting to be allowed to go to work. In the evening, his agitation became severe enough to require the placement of restraints. On November 15th, he continued to have periods of confusion and was noted to vomit several times despite having a nasogastric tube in place. Because of his extensive kidney injury and ongoing problems with the balance of electrolytes (a high sodium level), a nephrologist was consulted in his care. He assessed that although his kidney function was not normal, the dysfunction was not severe enough to require dialysis. The nephrologist recommended increased water intake through his feeding tube to treat the high blood sodium.

On November 16th, Mr. Bayrami was deemed to be ready for transfer to the regular surgical ward although it was noted that he continued to be confused and agitated. Earlier in the day he had removed his arterial line and nasogastric tube and had required restraints in order to permit their replacement. The doctor noted that Mr. Bayrami required the assignment of a one-to-one nurse to prevent him from removing the tubes that were all still in place. He was complaining of increasing abdominal pain, and the drainage from his surgical sites continued to be copious. His confusion continued in a fluctuating pattern, considerably worse in the evening and overnight. In the early morning hours of November 17th, he was noted to be pulling at his nasogastric tube and his IV tubing.

Mr. Bayrami was stable again when assessed by the ICU doctor on the morning of November 17th. He was transferred to the regular surgical ward at 15:15. On arrival on the ward he was not confused. He did however have a fast heart rate, ongoing copious drainage from his surgical drains, and ongoing high blood sodium. Over the afternoon and evening he was noted by the nurse to have increasing swelling of his body, particularly his arms.

In the early morning hours of November 18th, Mr. Bayrami was again very confused and removed his nasogastric tube. He was assessed by the surgical service and the nephrologist at 11:00. A CT scan of his abdomen was ordered and fluid administration was slowed. At 11:45, he became unresponsive and suffered a cardiac arrest. A "code Blue" was initiated and he was noted to suffer a "massive aspiration" during the placement of the endotracheal tube. His circulation returned after more than an hour of resuscitation and he was transferred to the ICU at 12:58. He remained unstable and did not regain consciousness. Mr. Bayrami died in the ICU at 19:58.

An autopsy was performed at the Royal Columbian Hospital. The pathologist testified that the cause of death was peritonitis (infection of the lining of the abdomen) secondary to the gunshot wound. The significant findings were a healing entrance gunshot wound on the right side of the torso anteriorly and a healing exit gunshot wound on the right side of the back. Associated with the gunshot wound were peritonitis, anasarca (total body fluid accumulation) and jaundice. The surgically repaired bowels and inferior vena cava appeared intact on examination at autopsy.

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

BAYRAMI	Mehrdad
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 the Chief Coroner, Province of British Columbia:

1. That the Death Review Panel into Intimate Partner Violence be confirmed and that this case be included in that review. In particular, the following issues arise:
   - Public education to improve access to services and reduce stigma regarding mental health issues.
   - Prevention, including exploration of the range of best practices in early counselling support for all involved persons should be considered. The availability of these at multiple access points at a variety of times and settings including through the health and criminal justice systems should also be considered.
   - Consideration of the perspective of affected people in the review process.
   - Undertake an analysis of the effectiveness of bail conditions in preventing further harm.

Presiding Coroner Comment: *Mr. Bayrami's ex-partner, daughter, and physician, testified that Mr. Bayrami had long standing mental health issues but that he had been reluctant to seek help for these. This was likely a factor in the intimate partner violence in the months before his death. Once the police became involved, following a series of complaints arising from ongoing and increasingly intrusive incidents, the efforts were entirely in law enforcement with no provision of assessment and counselling for Mr. Bayrami with the view to de-escalation and prevention. The situation became sufficiently concerning that he was arrested and jailed two weeks before the incident on November 8th. Bail conditions were imposed on his release, intended to prevent further incidents. However Mr. Bayrami failed to comply with these.*

The jury heard that the Chief Coroner can constitute a Death Review Panel to review multiple deaths due to common factors. These reviews are undertaken where there are complex issues that require the expertise and collaboration of professionals in the field to produce evidence-based recommendations. Intimate Partner Violence fits this requirement and the jury recommends that a death review panel be convened and that this case and the above considerations be included in the review.

To the British Columbia Director, Police Services:

2. Include a review of the specific arrangements for provision of Emergency Response Team (ERT) services as a component of the reporting required by Police Bodies in British Columbia.

Presiding Coroner Comment: *The jury heard that there are a variety of police governance arrangements around the province and that each individual police board determines the range of services required and how they are delivered. This includes highly specialized services like Emergency Response Teams where considerable ongoing training and expertise is required. In many circumstances, municipal departments have joined to provide these services, but in others individual departments continue to provide their own. Specific reporting on this important and high profile service should be mandatory as a component of the oversight of police services.*

3. Establish and publish provincial standards for ERT services including:
   - The structure and composition of ER Teams, including required experience and qualifications of members.
   - Recruitment and ongoing assessment of participants.
   - Training, with proportionate attention to approaches such as de-escalation in all aspects of ERT operations.
   - Communication plan for dealing with affected family members.

Presiding Coroner Comment: *The role of Director of Provincial Police Services as specified in Section 40 of the Police Act includes the establishment of standards for these and other policing functions. Currently there are no standards for the ERT functions in place.*

Testimony was presented that there are variable approaches to the recruitment and training of ERT members. The jury heard that considerable individual and tactical decision-making is required during ERT activities and that experience and training are very important. The daughter of the deceased also testified that the lack of communication and support provided to her following the incident furthered her distress.

4. Implement a non-fault finding timely, external, expert operational review of all ERT cases with adverse outcomes including this case. This should focus on review of all three aspects of these operations with the view to directly informing the ongoing improvement of training, and supporting the modification or addition to guidelines and standards of practice described above.

Presiding Coroner Comment: *The Independent Investigations Office (IIO) is in place to investigate all of these incidents from the perspective of the necessity for legal follow up. As this process can result in referral for prosecution, the directly involved subject officers have the right not to participate in the review. These processes may be lengthy and it may be several years before there is the opportunity to review the case from the perspective of practice improvement. It was therefore proposed that Police Services should explore options for an external, non-fault finding expert review for quality improvement purposes.*

5. Public reporting of an aggregate analysis of police involved deaths in BC, including trends, lessons learned and plans for prevention and mitigation of harm.

Presiding Coroner Comment: *Given that there may be commonalities between the circumstances of police involved deaths, these should be transparently analyzed and specifically reported on in order to develop evidence-based preventative strategies.*

6. Creation of a system or process that will flag and automatically initiate a review of multiple calls/files relating to a single person, with the goal to initiate intervention as needed.

Presiding Coroner Comment: *The jury heard that although all call outs are recorded on the Police Prime system, there is no easy way to flag when multiple calls/incidents pertain to a single individual. The constable who took over Mr. Bayrami's file in the month prior to this incident testified that she felt proactive steps should have been taken earlier in the course of these events when it became clear that a worrisome and escalating pattern of incidents was emerging.*

7. Requirement for all Provincial ERT to create and maintain a formal agreement with a number of psychologists who are retained to support the negotiators during incidents involving the ERT.

Presiding Coroner Comment: *On the day of this incident, there was considerable confusion with respect to accessing a psychologist to support the negotiators. Although some names of qualified psychologists were available, there was no explicit expectation that they be available on call to the ERT. Over the course of the five hours of this incident, there was sufficient time to engage direct professional assistance in the negotiations if such a service was prepared/required to be available.*

8. Requirement to have a victim services worker assigned to the family members from the point of contact to provide support, including transportation, communications and advocacy.

Presiding Coroner Comment: *Mr. Bayrami's daughter testified that on the day that her father was shot, she was left to navigate the system on her own, with very little information conveyed to her about what had happened. Detailed information about the incident was transmitted over news media before it was communicated to her. The trauma of these events has caused her significant and profound distress, and she believes that the lack of support has additionally hampered her recovery.*

9. Record incident through phone, blackberry or other pertinent communication devices in a way that does not require human intervention, with the goal to provide increased evidence for future reviews or inquiries.

Presiding Coroner Comment: *The jury heard sworn testimony of different accounts of the same events from different individuals, particularly regarding the transmission of information between officers involved in this incident. Although all police radio transmissions are recorded with transcripts available for review, the jury heard that a great deal of the communication of circumstances,*

instructions/commands given, and decisions made were conveyed between officers (both at the scene and at headquarters) over cell phones. Much of the direct communication with Mr. Bayrami during the incident was over a cell phone and only the officer's side of that communication was available for review because of technical difficulties. None of the police conversation over cell phones during these incidents is currently recorded and therefore cannot be examined as part of the record of the incident to resolve any discrepancies in individual accounts.

To the Minister of Health of British Columbia:

10. In order to support the full range of evidence-based bio/psycho/social care in mental illness, family doctors and others should have access to supportive services for their patients including psychological support in conditions such as depression.

Presiding Coroner Comment: *In the months prior to this incident, Mr. Bayrami was under the care of his family physician who diagnosed a severe depression, prescribing medication and providing some limited counselling. Despite some improvement of symptoms with this treatment, his behavioural issues escalated. Mr. Bayrami's ex-partner and his daughter believed that access to some more specific counselling would have uncovered the severity of the situation and may have led to preventive interventions.*

11. In order to support ongoing quality improvement, Trauma Services BC should establish a mandatory process for the multidisciplinary review of trauma cases resulting in death.

12. Trauma Services BC should ensure a mandatory performance improvement process for all hospitals involved in BC's system of organized trauma care incorporating clearly defined system performance measure and quality of care indicators.

Presiding Coroner Comment: *Mr. Bayrami's medical care following the gunshot was complex and involved many providers of care including prehospital, medical, nursing and surgical services. The jury heard from Dr. David Evans, the Medical Director of Trauma Services BC, that this group has the mandate to improve the quality of trauma care services across the continuum. Comprehensive multidisciplinary reviews of all trauma related deaths are included in accreditation guidelines, and are mandatory in many jurisdictions as they provide a very useful tool for the identification of systemic issues that can be addressed to improve outcomes. Another important component of the quality improvement is the establishment and monitoring of performance indicators.*

13. Undertake a review with the goal of prevention, including exploration of the range of best practices in early counselling support in intimate partner violence for all involved persons should be considered. The availability of these at multiple access points at a variety of times and settings including through the health and criminal justice systems should also be considered.

14. Create a directory of services identified in recommendation 13 which is accessible by both the medical community and general public, with an eye to improve access to support for people in distress.

Presiding Coroner Comment: *Mr. Bayrami was known to be at risk for months before his death. There were numerous points of contact with the justice and health systems and at each of these there was the opportunity to refer him for specialized assessment and care recognizing the potential for intimate partner violence in this case. There is a need for access to specific services on referral from police services, family physician and other primary health care providers, and directly from patients and families themselves.*

To the Chair of the Board of Fraser Health:

15. Direct the Patient Care Quality Review process at Royal Columbian Hospital to review.

Presiding Coroner Comment: *The jury heard from the providers involved in this case that there is a process for the review of deaths in hospital for institutional quality improvement purposes and that no such review had been conducted in this case. Given the complexity and the unexpected outcome this case should be reviewed by that process.*

To the Ministry of Education:

16. Create curriculum for the BC school system that addresses issues of mental health throughout the K-12 education system.

Presiding Coroner Comment: *Mr. Bayrami's daughter felt that lack of understanding of mental health issues and ongoing societal stigma impeded both her father's and her own timely access to assistance with these issues in their family. Mental health should be incorporated as a component of the health curriculum in schools in order to provide reliable and accurate information to improve general understanding and awareness and remove barriers to care.*