BRITISH COLUMBIA

Ministry of Public Safety
and Solicitor General
Coroners Service
Province of British Columbia

File No. :2015:0380:0002

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

MUKUYAMA	**Kevin Seiji**
SURNAME	GIVEN NAMES

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

in the Province of British Columbia, on the following dates November 14-17 2016

before: Brynne Redford, Presiding Coroner.

into the death of MUKUYAMA (Last Name) Kevin (First Name) Seiji (Middle Name) 42 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: February 11 2015 17:29

Place of Death: Chilliwack General Hospital (Location) Chilliwack, B.C (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Acute Cocaine Toxicity During Restraint

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: Atherosclerotic Cardiovascular Disease

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

The above verdict certified by the Jury on the 17 day of November AD, 2016

Brynne Redford
Presiding Coroner's Printed Name


Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Ms. Brynne Redford
Inquest Counsel:	Mr. Bryant Mackey
Court Reporting/Recording Agency:	Verbatim Word Services
Participants/Counsel:	Royal Canadian Mounted Police/Mr. Mark East and Mr. Rory Makosz

The Sheriff took charge of the jury and recorded 6 exhibits. 24 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 Findings 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 Findings and Recommendations.

Mr. Mukuyama was described by his family as kind and loving. He struggled with substance use and mental health issues, including anxiety and depression, but was generally in good health. At the time of his death, he resided in a private residence in Chilliwack, British Columbia.

On the afternoon of February 11, 2015, Mr. Mukuyama's friend and roommate awoke to find him disoriented, incoherent and seemingly intoxicated. Mr. Mukuyama had used an unknown weapon to cause a puncture injury to an animal that resided in the home and, out of concern for both Mr. Mukuyama and the injured pet, his roommate contacted 911at 16:02 hours to request emergency services.

Chilliwack RCMP responded to Mr. Mukuyama's residence, first arriving at 16:06 hours. There are conflicting accounts of what transpired following police arrival. However, evidence heard by the jury suggests that at the time of police arrival, Mr. Mukuyama was situated in the kitchen, seated on a chair and holding a glass marijuana water pipe in his hand. Police officers observed Mr. Mukuyama from various points outside of the kitchen and he was not responsive to verbal commands. When Mr. Mukuyama appeared to accidentally drop the marijuana pipe, police officers entered the kitchen and an altercation ensued. During the altercation, at approximately 16:14 hours, the senior officer on scene directed that a Conducted Energy Weapon ("CEW" or "taser") be deployed. Mr. Mukuyama was tasered and immediately placed in handcuffs while face-down on the kitchen floor.

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After being tasered, Mr. Mukuyama was initially conscious and breathing without difficulty. However, within minutes, Mr. Mukuyama's breathing became shallow and he then became unresponsive. Mr. Mukuyama's handcuffs were removed and police officers began Cardiopulmonary Resuscitation ("CPR"). Although at least one RCMP vehicle at the scene was equipped with an Automated External Defibrillator ("AED"), the device was not used.

Chilliwack Fire Department arrived at Mr. Mukuyama's residence, followed shortly thereafter by BC Ambulance Services ("BCAS") at 16:23 hours. Of note, when police first arrived at Mr. Mukuyama's residence, BCAS personnel were requested to be on "standby." There were varying understandings, however, of what exactly "standby" meant in these circumstances. A number of witnesses expressed concern about the length of time that elapsed before BCAS arrived on scene.

Upon arrival at the residence, Primary Care Paramedics took over Mr. Mukuyama's care and called for Advanced Care Paramedics, who provided a higher level of care at the scene and then transported Mr. Mukuyama to Chilliwack General Hospital. Mr. Mukuyama arrived at Chilliwack General Hospital at 17:05 hours, but despite ongoing efforts, was pronounced deceased at 17:29.

Toxicological analysis was completed on blood samples obtained after Mr. Mukuyama's death and found cocaine and its metabolite present within a range where non-lethal and lethal concentrations overlap. A post-mortem examination was conducted at Royal Columbian Hospital on February 13, 2015. The pathologist concluded that Mr. Mukuyama died as a result of acute cocaine toxicity during restraint. Mr. Mukuyama was also found to have atherosclerotic cardiovascular disease, which the jury considered a contributing factor in his death.

Unlike several other police forces within Canada, including the Vancouver Police Department and Ontario Provincial Police, the RCMP does not have a comprehensive Mental Health Strategy that focuses on members of the public experiencing mental health and substance use issues. Although other police detachments, including Surrey RCMP, have a specialized mental health car available to respond to calls involving individuals with mental health issues, this is not a service currently available in Chilliwack. Chilliwack RCMP does have a specialized Mental Health Liaison Officer who works closely with clients with mental health and substance use concerns, though this officer was not involved with Mr. Mukuyama.

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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 Dispatch Services for Chilliwack RCMP, BC Ambulance Services, Fire and 911:

1. Conduct a review of dispatch services provided in relation to Mr. Mukuyama.

Presiding Coroner Comment: *The jury heard that police, fire, and ambulance each have their own dispatch services, which are separate from 911 services. Information that was not communicated in the initial 911 call was transmitted to police via dispatch. The jury heard that BCAS was dispatched to a "routine" call and did not have all relevant information about the circumstances of Mr. Mukuyama's medical distress at the time of their arrival.*

2. When a complaint comes into 911 and multiple services are requested, ensure that all requested agencies are notified immediately.

Presiding Coroner Comment: *The jury heard that although both police and ambulance were requested at the time of the initial 911 call, fire and ambulance were not dispatched to the scene until after Mr. Mukuyama was tasered and already in medical distress.*

3. Explore options to allow Fire and Ambulance to access and monitor RCMP communications when responding to a scene.

Presiding Coroner Comment: *The jury heard that, in the past, other first responders could access the RCMP radio channel in Chilliwack to obtain information about an incident. However, as a result of technological changes that have been made, this is no longer possible.*

To the Ministry of Health:

4. Consider fully funded counselling for people with mental health and/or addiction issues, as recommended by a Medical Doctor and for as long as needed, in order to prevent mental health relapse.

Presiding Coroner Comment: *The jury heard that Mr. Mukuyama had a history of substance misuse, anxiety and depression. Mr. Mukuyama's physician gave evidence regarding the efficacy of counselling, but noted that the high cost of private therapy can be a significant barrier to access.*

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To the Royal Canadian Mounted Police:

5. Prioritise increased training opportunities relating to awareness of signs and symptoms of acute medical distress, inclusive of substance use induced crisis, as well as strategies for de-escalation and containment when no other person is at risk.

Presiding Coroner Comment: *The jury heard evidence relating to Mr. Mukuyama's behavior and demeanor prior to being tasered. Additional training regarding medical distress and de-escalation strategies could provide alternatives to CEW deployment in similar circumstances.*

6. Ensure that all new recruits are fully trained, but not necessarily certified, in the use of all weapon systems and related policies.

Presiding Coroner Comment: *The jury heard that some, but not all, RCMP members are trained in the use of CEWs. As those who are not certified to carry a CEW may nevertheless be present when a CEW is deployed, there may be benefit to providing training to all members regarding the use of these devices.*

7. Consider equipping all RCMP officers with a body-worn camera.

Presiding Coroner Comment: *The jury heard conflicting accounts of what transpired following RCMP arrival at Mr. Mukuyama's residence. The use of body-worn cameras could provide an objective account of what occurred in cases where an individual dies following a police altercation, providing additional learning opportunities to prevent future deaths under similar circumstances.*

8. Ensure the maintenance and consistent application of uniform standards and codes of conduct for all RCMP members.

Presiding Coroner Comment: *The jury heard that there were members of various ranks present at Mr. Mukuyama's residence, with differing perspectives and opinions on what was required to respond to the circumstances.*

9. Review Mental Health Strategies implemented by the Vancouver Police Department and Ontario Provincial Police and prioritize the creation and implementation of a similar Mental Health Strategy for the RCMP.

Presiding Coroner Comment: *The jury heard evidence that the RCMP does not currently have a comprehensive Mental Health Strategy.*

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10. Require that all officers certified to use a CEW be simultaneously trained in advanced emergency first aid, specifically including the use of an AED.

Presiding Coroner Comment: *The jury heard evidence that CEW training and certification is required once per year but that first aid and AED-related training is required every two to three years. Simultaneous training may help ensure an appropriate first aid response in the event of medical distress following CEW deployment.*

11. Require that every RCMP member carrying a CEW also carry an AED in their vehicle.

Presiding Coroner Comment: *The jury heard evidence that only supervising officers carry AEDs in their vehicles. Although there was an AED on-site at the time a CEW was used on Mr. Mukuyama, given the potential risk associated with use of a CEW, it may be beneficial for all members carrying a CEW to have direct access to an AED. The jury also heard evidence about the importance of prompt intervention when an individual is experiencing cardiac arrest.*

12. Establish policy related to CEW deployment requiring the officer that deploys the CEW to take responsibility for medical over watch of the individual.

Presiding Coroner Comment: *The jury heard that no single officer is responsible for medical care when a CEW is deployed, but that this is instead a shared responsibility. Identifying a specific individual to take responsibility when a CEW is deployed may increase the likelihood that appropriate medical care is provided if an individual goes into medical distress.*

13. Establish policy that requires the immediate retrieval of an AED when an individual is in medical distress.

Presiding Coroner Comment: *The jury heard that although there was an AED within a police vehicle located at Mr. Mukuyama's residence, it was not obtained from the vehicle before or after Mr. Mukuyama going into medical distress.*

To the Royal Canadian Mounted Police and Fraser Health Authority

14. Prioritize the creation and implementation of a specialized Mental Health patrol car (available 24 hours per day, seven days a week) in all communities where this service is not currently available.

Presiding Coroner Comment: *The jury heard that Chilliwack RCMP does not currently have a specialized Mental Health Car available.*